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ABSTRACT

Several recent reports have examined the needs of families with substance abuse problems in the child welfare system, and documented the barriers to obtaining social services. This report aims to inform substance abuse agencies in depth about the changes in child welfare laws and practices that affect substance abuse agencies policies and practices, as well as their clients and their children. To meet these aims, materials were gathered and analyzed from seven exemplary sites that have forged stronger alcohol and drug service-child welfare service links than most of their counterparts. Current and emerging responses in state and local policies are documented, and models of child welfare services and substance abuse treatment agencies practices that have been shown to improve outcomes for parents and their children are described and updated. The report also provides useful guidelines for state and local treatment agencies in redesigning policies and programs for parents who have been reported for child abuse and neglect, including treatment for parents and targeted prevention and intervention for their children. Appendixes include documentation from the exemplary programs discussed in the document. (Contains 22 references.) (GCP)

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Technical Assistance Publication (TAP)Series

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FOREWORD

The problem of substance-abusing families in the child welfare system is one of the important frontiers of policy and practice for State and local officials. It is one of the most important intersections of two systems that usually work separately, with different funding streams, professional backgrounds, and perspectives on what clients need.

Yet important progress has been made in recent years in addressing this problem. The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) and its Federal partners, most notably the Administration for Children Youth and Families (ACYF), Office of Child Abuse and Neglect (OCAN), have jointly sponsored a range of activities that support the recommendations first identified in the HHS Report to Congress *Blending Perspectives and Building Common Ground.* This publication is part of our response to the recommendations in that important report.

This Technical Assistance Publication offers a unique perspective on the growing contacts across the divide that too often prevents child welfare and substance abuse agencies from working together as closely as they need to in order to help children and families affected by substance abuse. As this publication makes clear, the seven sites that are described are all the more important for the practical knowledge and policy changes that they have combined to bring about genuine change. The framework that this document sets forth, drawn from the experience of sites from around the Nation, offers other States and localities an excellent tool for addressing these issues.

Together with its Federal partners, SAMHSA is committed to continuing to improve services and outcomes for families involved in the child welfare system and affected by substance abuse.

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I. INTRODUCTION

Several recent reports have examined the needs of families with substance abuse problems in the child welfare system, and documented the barriers to obtaining social services. One study explored the challenges of working across service systems and presented innovative models for linking child welfare and substance abuse treatment agencies to deliver more effective services.[1] Another study discussed substance abuse among children placed in foster care and the difficulties child welfare agencies face in making timely permanency decisions for such children.[2] A third looked at the impact of substance abuse on the child welfare system and why the child welfare system has failed to respond.[3] While all three of these reports proposed solutions, a fourth[4] concentrated on how residential treatment programs are uniquely suited to children and families in crisis. The fifth, required by Congress under the Adoption and Safe Families Act (ASFA), examined addiction, recovery, and child maltreatment, and tried to determine the scope of these problems.[5] These earlier papers did an excellent job of describing the problem and offering possible solutions. So why write a new report? Several reasons are offered:

1. What is needed now is an update and summary of the lessons learned from reform efforts and innovative projects. These lessons, drawn from the seven case studies provided in this report, are essential to inform the next round of project development and implementation. This orientation to what works requires that some of the earlier ventures be critiqued to alert those planning new projects of the outcomes of these efforts.

2. The earlier reports paid much more attention to the challenges facing the child welfare system than to those confronting the substance abuse treatment and prevention agencies. This report seeks to redress this imbalance because a preoccupation with child welfare services (CWS) tends to relegate substance abuse treatment agencies to secondary status, which is counter to the shared responsibility needed. If accountability and resources only run one way—if only the child welfare system, the court, or the substance abuse agencies are involved––then clients are unlikely to benefit.

   At one point, many believed that establishing bilateral relations between CWS and substance abuse treatment agencies was sufficient to respond to the substance abuse problems of parents in the child welfare system. Today, although the two agencies do play critical roles, the courts; mental health, family violence, and child development agencies; the juvenile justice system; schools; and many others must assist the two sets of agencies in addressing child abuse and substance abuse.

3. Finally, the policy context has changed:

   - The ASFA legislation of 1997 did not exist when some of the earlier reports were written. This law identifies the circumstances in which abused or neglected children need not be returned to their parents by requiring States to terminate parental rights when children have been in foster care for 15 of the previous 22 months. ASFA also mandates that child welfare agencies plan not only for family reunification but also for a permanent home, so that an alternative is in place if parents' rights are terminated. This legislation has had a major impact on substance abusers who want to reunify and parent their children.

   - The implementation of welfare reform may be affecting child protective services.[6] Reductions in cash welfare assistance may increase pressure on stressed families and thus increase the likelihood of child abuse and neglect. While this prediction has not come to pass fully, some families have clearly been affected by time limits in ways that affect their children.[7]

   - The report to Congress (described in more detail below) mandated by ASFA identified five broad areas of policy action that have guided this product and a series of joint efforts by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Administration on Children and Families (ACF).

   - Treatment monitoring and CWS case management now have available measures of effectiveness that had not been developed when the earlier reports were issued. These measures make it possible to determine which model programs are working and how they might be improved.

   - State and local innovation is 2 years further along than when the data were collected for most of these reports, and this progress has changed the barriers facing CWS-substance abuse bridge builders. It has become more difficult to say, "no one has ever done it that way" when considering CWS-substance abuse reforms. Documenting the experience of these projects through the case studies and lessons offered in this document is a way of providing a clearer map for the next wave of innovators.

The aims of this report include:

- Informing substance abuse treatment agencies in depth about the changes in child welfare laws and practices that affect substance abuse agencies' policies and practices, as well as their clients and their children;

- Documenting current and emerging responses in State and local policies;
- Describing and updating models of CWS and substance abuse treatment agencies' practices that have been shown to improve outcomes for parents and their children; and
- Providing useful guidelines for State and local treatment agencies in redesigning policies and programs for parents who have been reported for child abuse and neglect, including treatment for parents and targeted prevention and intervention for their children.

To meet these aims, materials were gathered and analyzed from seven exemplary sites that have forged stronger alcohol and drug service (ADS)-CWS links than most of their counterparts. Materials were also compiled from a variety of other States and communities.

Statement of the Problem

Several million children have been abused and neglected by parents with substance abuse problems.[8] Child welfare workers are aware that most of their cases involve families with drug and alcohol problems, but they know this only anecdotally. They are usually not required to ask about substance abuse, and even when they do, they have no place to document the information systematically. The result is that most parents who need addiction treatment do not obtain it, and when they fail to show progress in child caretaking, they may lose their children permanently. This chain of events has led policymakers to ask how child welfare agencies can work more collaboratively with substance abuse treatment providers to improve conditions in these families. Another question is how substance-abusing parents in the child welfare system can obtain the services that they need to recover, unify their families, and lead healthier, more productive lives.

Substance use is generally believed to be associated with the abuse and neglect of children. The 1999 U.S. Department of Health and Human Services (DHHS) report to Congress[9] on this topic cites evidence that parents who abuse alcohol and drugs discipline their children less effectively than other parents. They do not attend to their children's emotional cues, overreact with harsh discipline, and tend to be poor role models. And while substance use may precipitate child maltreatment, the reverse may also be true. Child abuse, particularly sexual abuse, may lead to the use of alcohol or drugs as a way of enduring the trauma of that abuse.

In addition to the risk for parental maltreatment, the children of substance abusers are likely to display high energy levels and difficult temperaments. They tend to fall in the low-normal range of physical, intellectual, social, and emotional functioning.[10] Children exposed *in utero* to alcohol can be born with fetal alcohol syndrome, a known cause of mental retardation, or with alcohol-related disorders, such as congenital anomalies and cognitive-behavioral deficits.[11]

The Scope of the Problem

The National Household Survey on Drug Abuse has found that 8.3 million American children—11 percent of all children—live in a household in which at least one parent needs treatment for alcohol or illicit drugs.[12] This suggests that in the typical classroom, which contains nearly 30 children in most schools, 3 children are significantly affected by substance abuse. Other studies have shown that 40 to 80 percent of children in the child welfare system are affected by alcohol and drug use by their parents.

The following table shows both the number of children in child protective services (CPS) who are affected by parental substance abuse and the general population of CWS children. The middle column of the table shows the relatively small number of children actually placed in protective custody compared to the number of reports of abuse and/or neglect that are made.

Estimated Cases Reported, Investigated, Substantiated, and Placed in Out-of-Home Care in 1997 by Child Protective Services

	All Children Affected by Child Abuse/Neglect	Children Affected by Child Abuse/Neglect *and* Parental Substance Abuse
Annual Children Reported	2.8 million[13]	Unknown
CPS Investigations (Estimated)	1.82 million	Unknown
Substantiated Cases	903,000 victims 532,063 substantiated cases	451,500 (50%)[14]
Young Children (ages 0-7)	451,500[15]	352,170 (78%)[16]
Placed in Out-of-Home Care	177,000[17]	115,050 to 132,750 (65-75%)
Point-in-Time Census Total Population of Children in Out-of-Home Care (9/30/99)	~ 568,000[18]	369,200-426,000 (65-75%)

A survey of workers in public and private child welfare agencies indicates that alcohol and drugs significantly affect 50 percent of families suspected of serious child abuse/neglect.[19] At sites across the country (Oregon, Connecticut, Sacramento County) where assessments have been conducted or open child welfare cases have been reviewed, estimates consistently indicate that alcohol or drugs have played a significant role in the abuse and neglect in approximately 60 percent of cases.[20] Among young children in urban areas of two States (California and Illinois), 78 percent—or 352,170, extrapolating from national statistics—are estimated to be in out-of-home care due to parental substance abuse.[21]

In cases in which the child has been placed in protective custody, estimates of parental substance abuse range from 65% to 75%.[21] Therefore, the annual number of children placed in out-of-home care suggests that 115,000 to 133,000 are affected by parental substance abuse. Using these estimates and a point-in-time census of the total population of children in out-of-home care on September 30, 1999, between 369,200 and 426,000 of the children in out-of-home care have parents with substance abuse problems, that must be treated before the children are allowed to return home. Anecdotal evidence suggests that over 90% of dependency court cases involve children affected by parental substance abuse.[22]

Treatment, however, is difficult to come by, especially for mothers. In 1996-97, approximately 1.8 million individuals were admitted to State-monitored drug and alcohol treatment programs in the entire country.[22] Only 29.6 percent of those admissions (approximately 532,800) were women. Therefore, the substance-abusing mothers of the approximately 400,000 children in out-of-home care constitute half of all women's admissions per year (assuming that mother-to-child ratios are approximately 1.5, i.e., each mother represents 1.5 children[23]). Finding appropriate substance abuse services requires daily competition among child welfare clients; women who seek treatment on their own; women who are referred by the criminal justice system (particularly drug courts), primary health care providers (particularly for pregnant women), the Temporary Assistance to Needy Families (TANF—formerly Aid to Families with Dependent Children [AFDC]) program; and, of course, the men who represent 70.4 percent of all admissions.

Moreover, existing substance abuse treatment slots may be further limited by the differing levels of care needed by different groups of parents. To make the best possible use of these scarce resources, the differences among the following must be better understood:

- Parents who are *using* a substance;
- Those who are *abusing* the substance, i.e., who are experiencing negative consequences as a result of their use; and
- Those who have crossed the line to addiction and *chemical dependency*, in which brain chemistry has been altered and a compulsion for continued drug use exists, despite negative consequences for the family.

Preliminary data on these differences come from an interim 1999 evaluation of the Sacramento project described later in this report. An examination of 2,699 child welfare cases determined the relative rates of users, abusers, and addicts. In this sample, 12 percent *used* occasionally or regularly, 25 percent were classified as substance *abusers*, 60 percent were considered *chemically dependent*, and no drug use was found for 3 percent. These findings have implications for treatment; more than twice the number of substance abuse treatment slots need to be allocated to the most severely addicted (the chemically dependent), while alternate responses are needed for those who are substance abusers.

Aside from the scarcity of treatment, other impediments prevent substance abusing parents in the child welfare system from obtaining treatment. These fall into two general categories: conflicting time requirements and institutional barriers.

The Problem: The Five Clocks

The concept of the "four clocks" was originally introduced to frame the four very different timetables faced by front-line workers and clients in different, but overlapping systems:[24]

1. The first clock is the timetable now imposed by TANF, which requires clients to find work within 24 months, when benefits cease. Twenty-four months is the Federal maximum; some States have lower limits. As a result, some participants have already reached the cutoff point.

2. The child welfare system timetable, the second clock, differs from State to State and, sometimes, from county to county. The overall timetable demands 6-month reviews of a parent's progress toward becoming a safe caregiver, enabling reunification with children who have been removed from the home. ASFA requires a permanency hearing at 12 months and a filing for termination of parental rights if the child has been in out-of-home care for 15 of the prior 22 months;

3. The recovery process, which often takes longer than substance abuse treatment funding allows, is governed by the third clock. Research has shown unequivocally that good outcomes are contingent on adequate length of treatment, which may be incompatible with child welfare deadlines for parents. Some have summarized the recovery timetable as "one day at a time, for the rest of your life."

4. The fourth, and perhaps most important, clock is the developmental timetable that affects children, especially younger children, as they achieve—or fail to achieve—bonding and attachment during their first 18 months. This is critical, according to new research on brain development.

Proposals for new ADS-CWS linkages should address the impact of these linkages on the five clocks.

This metaphor of four clocks is a useful one that has helped interagency groups understand how different policies affect children and families at the intersections of these systems. However, the concept needs to be amended to add "no CPS clock" cases—families with substance abuse problems who have been reported to CPS after a decision to keep children in the home. CPS workers might decide to keep the children with their parents because they cannot determine the extent to which the substance abuse presents an immediate, significant risk to child safety. In such circumstances, no official ASFA clock is started. Yet, these families need links to substance abuse treatment services in case the risk to the child was underestimated or the child is threatened by safety issues arising from parental or caretaker substance abuse.

Finally, *a fifth clock* exists, and keeps track of how much time is required for agency staff to respond to the demands imposed by the other four clocks. This clock illuminates the lack of a sense of urgency in both sets of agencies about the deadlines imposed by the other clocks. As was noted in a recent meeting of CWS and substance abuse treatment stakeholders:

> We have known about the impact of prenatal drug exposure since the mid-80s; we have been working on integrated services since the mid-60s and before; and John Dewey told us everything we need to know about "the whole child" in 1902. How long will it take us to act at scale on these issues of children and families who are before us every day?[25]

All services are not equally urgent. But providing assessment and intervention for very young children who may have been prenatally exposed and who are exposed daily to the environmental and familial effects of alcohol and drug use is surely more urgent than some other services. In making decisions about priorities and resources, agencies and staff need to remember that the clocks never stop. The new ASFA and TANF time limits, combined with what is known about development, attachment, and bonding, demand more client-centered practice than ever before.

Agencies and their staffs need to be cognizant of the institutional version of the denial and avoidance so often manifested by clients with addictions. Agencies that are satisfied with pilot projects rather than comprehensive policy agendas are exhibiting a kind of institutional denial that says, as clients sometimes do, "I don't really have a problem—I can handle it."

The Challenges for ADS and CWS Agencies

The earlier reports on ADS-CWS issues primarily stressed the differences between the two types of agencies in clients, funding sources, training and orientation, information systems, and underlying values. These studies and others, however, have tended to focus more on the entry point for children and families into the child welfare system than on the alcohol and drug prevention and treatment agencies that are their potential partners. This section reviews some of the most important challenges in building ADS-CWS linkages from both the substance abuse and child welfare perspectives.

Challenges from the ADS Perspective

Too Many Competing Demands. Staff and leaders of ADS agencies often say that although they would like to respond more effectively to children and parents in the child welfare system, these families are merely one more group seeking attention from hard-pressed ADS agencies with limited resources. Substance abuse treatment agencies are under pressure in some States from criminal justice agencies wanting more slots for incarcerated persons—more often males than females. The recent history of earmarks within the primary funding source for treatment agencies—the Substance Abuse Prevention and Treatment Block Grant (SAPTBG)—provides further evidence of the categorical approach to allocating resources for targeted groups, including intravenous drug users, as well as prevention and women's programs. If the child welfare agency offers to form a partnership or requests a priority admission status for its clients funded by the substance abuse treatment agency alone, based on these other competing priorities, the treatment agency will almost certainly be forced to decline.

Substance abuse treatment agencies preparing to work with CWS agencies must specify what changes they are making to accommodate women and children.

Different Tracking Systems. Substance abuse treatment agencies track clients in a very different way from CWS agencies. They count clients referred to treatment and clients who complete treatment "successfully" or "unsuccessfully." Treatment agencies may not collect data on assessments of parenting effectiveness. Their intake systems typically do not count children of substance-abusing clients as part of the case, and few can retrieve information from their treatment databases on the status of the children of clients in the CWS, welfare, or Medicaid systems.

Client engagement and outreach are essential components of any ADS-CWS partnership proposal.

Waiting Lists. In the substance abuse treatment system, funding has always been inadequate to serve all clients who request treatment, so clients must be motivated to remain on waiting lists. If a client fails to show up upon reaching the top of the list, another client will be selected. This practice is a barrier to serving parents in the child welfare system, who may not be motivated to receive treatment and may have been referred by a dependency court rather than requesting treatment voluntarily. Resistant clients present a fundamental new challenge to substance abuse treatment agencies in client engagement, motivation, and outreach strategies.

Women and Children as a Priority. Historically, most admissions to publicly funded substance abuse treatment are men. Access to comprehensive, gender-specific programming may conflict with competing priorities for other groups in need of substance abuse treatment, including primary health, criminal justice, and other social service programs.

Attitudes Toward Clients. In substance abuse treatment agencies, workers may identify with clients with substance abuse problems because the workers often have a personal experience with addiction. In contrast, CWS workers may view abusive parents with alcohol or drug addictions as part of the problem instead of as clients whose strengths and needs require as much emphasis as their deficits.

The Capacity Gap. Despite the availability of new funding and new funding sources, important substance abuse barriers arise from the time lag between funding and program implementation. Creating new ADS treatment capacity requires time to construct or renovate facilities; train competent, adequately credentialed staff; address local zoning issues; and obtain licensing and certification.

Challenges From the CWS Perspective

Effectiveness of Substance Abuse Treatment. Some child welfare officials question the *effectiveness* of treatment. One State official had a very clear position about substance-abusing parents: "There really isn't much that works with these people." The good news is that, a year later, this same official was far more optimistic about the new bridge-building efforts between the two sets of agencies in his region and contributed to the design of the model used.

Information Systems Hide Alcohol and Drug Problems. Information systems actually mask alcohol and drug problems among CWS populations. The lack of clarity in most child welfare agency policies on how seriously substance abuse should be taken has started changing under the new time limits imposed by ASFA. However, most workers are simply not familiar with the screening and assessment tools available, and have not connected with ADS treatment staff who can provide the screening. Moreover, entering information on substance abuse problems into the database is optional in most States. As a result, child welfare workers typically enter such data into the child welfare information system only when the evidence is overwhelming, and CWS systems typically find it unnecessary to look for substance abuse in the parents they serve.

Lack of Response to Referrals. Some CWS agencies have identified clients' substance abuse problems and made referrals, only to find that substance abuse treatment agencies lack the capacity to serve these clients. This increases the skepticism of CWS staff about referrals and hardens their belief that services are simply not available. Yet, the most significant expansion in the history of services is occurring for parents who are in both the TANF and CWS systems.

Confidentiality Concerns. This barrier remains important in the perception of many CWS workers and supervisors. Due to the lack of information about policy issuances, the confidentiality barrier is sometimes cited because of a lack of trust rather than actual legal barriers.

The True Partnership

Some substance abuse and child welfare agencies have worked hard to overcome these challenges and have built effective new partnerships. To find out how they accomplished this, seven exemplary sites around the country were studied. They were chosen because they had forged stronger ADS-CWS linkages than most of their counterparts and exemplified promising practices that addressed several specific barriers. The goal was to examine innovative regional and statewide programs that were led by a substance abuse treatment agency (Jacksonville and Sacramento County), the courts (San Diego County and Miami), or a child welfare agency (Connecticut, New Jersey, and Cuyahoga County), and represented various stages of development. The Connecticut and Sacramento programs were well advanced in their implementation and were making refinements to their model that were equivalent to a second-phase innovation. The New Jersey, Cuyahoga County, San Diego County, and Miami programs were well along in implementation phases, while the Jacksonville project was in its early stages of development and implementation.

The State of Connecticut. Project Substance Abuse Family Evaluation (SAFE) instituted statewide substance abuse screening in the child welfare system and outstationed alcohol and drug specialists in regional child welfare offices; suspected substance abusers undergo assessment and, if necessary, treatment. Phase II provides assessment of barriers to treatment completion and intensive case management to increase "show rates" at assessment and treatment appointments.

The State of New Jersey. The Child Protection Substance Abuse Initiative assesses child welfare parents for substance abuse, develops a service plan with a ADS treatment counselor, and provides family advocates to improve engagement and treatment retention.

Sacramento County, California. The Alcohol and Other Drug Treatment Initiative trains workers, screens and assesses child welfare parents, provides intervention at the dependency court, and matches parents with treatment resources based on addiction severity and life functioning.

Cuyahoga County, Ohio. Sobriety Treatment and Recovery Teams (START), consisting of a CPS investigator and a family advocate, place mothers of drug-exposed newborns in substance abuse treatment; provide recovery support; and coordinate other services, such as medical care, vocational guidance, and child care.

Jacksonville, Florida. A joint case plan is developed through a family conference. TANF funds are used to outstation substance abuse counselors in CPS investigations units, where they conduct assessments and intervention, and provide linkages to treatment.

San Diego County, California. The Substance Abuse Recovery Management Systems assess and monitor the ADS treatment progress of parents in the dependency court and provide rewards and sanctions to achieve reunification or permanency in a timely way.

Miami, Florida. A dependency drug court monitors the progress of substance-abusing parents in treatment, and addiction specialists develop a comprehensives case plan for family recovery.

Data for the case studies come from the November 1999 stakeholders meeting on substance abuse and child protection convened by SAMHSA and ACF, as well as interviews during visits to each site.

The sites were visited by staff from Children and Family Futures during March and April 2000 to talk with staff about the reforms. These discussions were guided by a 10-element framework based on 5 categories of action in the 1999 report to Congress[26] and the recommended action agenda from the earlier reports.[27] The 10 framework elements were designed to measure the capacity of agencies to work as partners on the substance abuse needs of CWS clients:

1. *Underlying values and principles of collaborative relationships*. Agencies seeking a partnership often have different perspectives on whether substance abusers can be effective parents; whether the client is the parent, child, or family; and whether the goal is child safety, family preservation, or economic self-sufficiency. Agencies will not reach agreement until these underlying issues are discussed.

2. *Daily practice—client intake, screening, and assessment*. Partners typically screen clients for different categories of problems. Child welfare agencies investigate child abuse and neglect, while ADS treatment agencies look for substance abuse. For a successful collaboration, CWS agencies must ask clients about alcohol and drugs to refer users for treatment when appropriate, and substance abuse treatment providers must document the status of clients' children.

3. *Daily practice—client engagement and retention in care*. ASFA demands that clients meet their treatment goals in order to regain custody of their children before family reunification plans are abandoned.

4. *Daily practice—services to children*. Treating parents alone ignores the effects of substance abuse on the children and places the children at risk for developing addiction, as well as other maladaptive behaviors.

5. *Joint accountability and shared outcomes*. Jointly developed outcomes are the best indicators that both agencies agree on the goals of their partnership and how to measure their progress toward achieving those goals. Without agreement on accountability and outcomes, the partners may continue measuring their progress using their own, different measures of effectiveness.
6. *Information sharing and data systems*. These are the prerequisites for joint accountability; otherwise, the partnership will have no guideposts to determine whether its programs are effective.

7. *Budgeting and program sustainability.* Maximizing the full range of funding resources available to a State or community is the only way to develop financial stability for innovative approaches.

8. *Training and staff development.* In order for child welfare and substance abuse treatment workers to address the complex problems of their shared clients, they need ongoing interdisciplinary training. Conventional training will only deepen the divisions between agency staff.

9. *Working with the courts.* The courts establish and enforce time limits for family reunification and make judgments about parents' progress in substance abuse treatment. When the two agencies coordinate their decisions about a family, their shared perspectives can generate a better ruling.

10. *Working with related agencies and the community.* Many clients need help with parenting, education, and vocational guidance; medical and dental care; mental health care; housing; transportation; childcare; and domestic violence.

In the States and communities where ADS-CWS agencies have made the most progress in building partnerships, results can be summarized using this 10-part framework. A questionnaire was developed to assist sites in measuring their progress in each of these areas and markers of progress for each of the 10 elements were developed and are summarized in the matrix. These markers are presented from a developmental perspective of system linkages, and the better practices column includes all of the accomplishments listed in the first two columns.

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MATRIX OF PROGRESS IN LINKAGES BETWEEN ALCOHOL AND DRUG SERVICES AND CHILD WELFARE SERVICES

Element	Minimum/Adequate Practice	Good practice	Better practice
Underlying Values and Principles of Collaborative Relationships	Values clarification efforts have begun informally among senior staff Discussions have begun concerning the priority to be given to CPS parents in treatment programs The issues of different time limits and developmental needs of children have been identified as needing attention	A formal joint statement of principles has been negotiated between the two agencies covering responses to CPS parents with substance abuse problems Cross-system discussions and problem solving at senior, mid-management, and front-line practice levels are instituted	Formal values clarification efforts have included all staff of both agencies Both agencies have agreed upon joint agency goals to serve the whole family as their primary client
Daily Practice: Client Intake, Screening and Assessment	AOD workers have been out-stationed at CWS offices for screening and assessment [or] Contracted staff have been assigned screening and assessment roles for CWS parents Risk assessment includes a formal review of parents' ADS needs which is recorded for all clients	Joint case assessments and plans have been developed for CPS parents with substance abuse problems	ADS and CWS screening and assessment roles have been negotiated with clarity on both sides about which agency will perform each, using tools that have been revised and refined based on interagency discussions of how best to detect and follow up on substance abuse problems
Daily Practice: Client Engagement and Retention in Care	Agencies have begun "drop-off mapping" of the points at which parents are not responding to referrals and not complying with treatment requirements ADS and CWS staff have agreed on procedures for outreach to parents who miss appointments	Staff have been trained in motivational interviewing and/or other methods of engaging and retaining parents in treatment	Client relapse typically leads to a collaborative intervention to re-engage the parent in treatment and to re-assess child safety

MATRIX OF PROGRESS IN LINKAGES BETWEEN ALCOHOL AND DRUG SERVICES AND CHILD WELFARE SERVICES

Element	Minimum/Adequate Practice	Good practice	Better practice
Daily Practice: Services to Children	Agencies have begun to assess the Alcohol & Drug Service needs of children in the CWS system	Agencies have implemented substance abuse prevention and early intervention services for children in the CWS system, including the Independent Living Program	All children involved with child welfare services receive developmentally appropriate interventions to address their status as a child of a substance abuser
Joint Accountability and Shared Outcomes	Dual outcomes with some recognition of overlapping roles	Some shared outcomes but agencies feel primarily accountable for their own measures of success Agencies use outcome criteria in their contracts with community-based providers (who serve CWS-ADS parents) to measure their effectiveness in achieving shared outcomes	The child welfare agency has accepted shared accountability for recovery outcomes for its clients and the treatment agency has accepted shared accountability for child safety for the children of its clients
Information Sharing and Data Systems	Both agencies have documented the gaps in their current client information systems and have begun addressing them Alcohol and drug assessment at intake captures data about child needs among child welfare families Data on the overlap between TANF and child welfare parents is consistently available to both agencies and to ADS agencies An interagency process has identified the confidentiality provisions that affect ADS-CWS and court connections and has devised means of sharing information while observing these regulations	The two agencies have agreed upon information systems that track parents' referral, prior episodes in each system, progress in treatment, and family outcomes for those parents whom the agencies can regularly identify as shared clients	The agencies have developed and are fully utilizing information systems that can be linked to track parents through both agencies and monitor family and treatment outcomes, using data to re-allocate resources to the most effective programs

MATRIX OF PROGRESS IN LINKAGES BETWEEN ALCOHOL AND DRUG SERVICES AND CHILD WELFARE SERVICES

Element	Minimum/Adequate Practice	Good practice	Better practice
Training and Staff Development	Training has been provided for ADS staff in child welfare issues and child welfare staff in addiction issues	Training has been institutionalized with regular updates and a set curriculum that devotes adequate time to substance abuse & child welfare issues Court staff have been added to training groups	The two agencies and the court have agreed to develop and use cross-training models, not just one-way training for child welfare workers in addiction or ADS workers in child protection
Budgeting and Program Sustainability	The two agencies have agreed that funding from both agencies will be used for child welfare-related treatment Agencies have begun to develop an all-funds inventory of current treatment and children's services in the state/community	TANF, Medicaid, and other major funding sources for treatment are used regularly for funding treatment for child welfare parents	A multi-year funding plan has been developed that taps all relevant sources, including those beyond the direct control of substance abuse and child welfare agencies
Working with the Courts	The issue of relapse has been identified as a major area of difference between the two agencies and the courts and discussions are under way to negotiate a consensus on shared outcomes that reflects both child safety and recovery goals Dependency courts have documented current compliance with court orders for treatment and federal time lines and have developed corrective action plans	The two agencies have agreed on a common message they will give the courts on parents' progress in treatment The courts, ADS-CWS agencies and attorney groups have negotiated and developed a common approach for families with substance abuse problems	The two agencies, courts and attorney groups have agreed upon how aftercare will be monitored and what are the desired outcomes of treatment as they affect children and families

MATRIX OF PROGRESS IN LINKAGES BETWEEN ALCOHOL AND DRUG SERVICES AND CHILD WELFARE SERVICES

Element	Minimum/Adequate Practice	Good practice	Better practice
Working with Related Agencies and the Community	Child welfare and treatment staff have assessed parents' needs for related services frequently required by ADS-CWS involved parents (e.g., transportation, child care, family violence services, mental health services) Parent education courses for substance-involved child welfare parents include significant content on alcohol and drug issues	Staff are aware of how to identify and link families with the other services that are frequently needed by ADS-CWS involved parents and make referrals to those agencies Parent education courses are formally evaluated for their impact on parenting practices ADS and CWS agencies coordinate with law enforcement and corrections agencies to meet the needs of parents and their children affected by the criminal justice system (e.g., visitation and treatment while parents are incarcerated)	A fully collaborative process exists across agencies with the resources needed by parents with substance abuse problems, including screening, assessment, follow-up, and joint advocacy for the added resources needed in each system to adequately serve families who have co-occurring problems affecting their parenting, family stability, and risks to children

II. THE POLICY CONTEXT

Considerable progress has been made in addressing alcohol and drug services (ADS)-child welfare services (CWS) issues over the past 4 years. The forces underlying this progress are worth noting:

- Passage and implementation of both the Adoption and Safe Families Act (ASFA) and Temporary Assistance to Needy Families (TANF) have given new impetus to addressing alcohol and drug problems in both client groups, and this impetus has been further aided by the availability of new TANF funding and selected Title IV-E waivers granted to States.

- Alcohol and drug treatment agency heads and their child welfare counterparts in some States have taken risks in developing new connections with the other system. At least 20 States have set aside TANF funds for substance abuse treatment. As of late 2000, nearly $8 billion in TANF surpluses existed at the State level; these funds could provide first-rate substance abuse treatment services for 1.3 million women.[1]

- New tracking of child welfare clients and new substance abuse treatment monitoring systems have made possible the collection in some States and counties of much better information on the status of clients referred from child welfare to substance abuse treatment systems.

- State and national associations in both fields have addressed the problem in depth, with statewide and national meetings and negotiations among national groups representing State and local child welfare and substance abuse treatment agency directors.

- Local dependency and family courts, which are, by definition, critical players in the child welfare system, have implemented a wide range of innovations over the past few years, including drug courts. These innovations have pressured both clients and systems to respond to the new time limits and prior difficulties in client engagement and retention.

The Policy Context—What Does ASFA Mean?

ASFA (P.L. 105-89), signed into law on November 19, 1997, requires States to move children more quickly through foster care into permanent homes. Previously, Federal law did not require States to initiate termination of parental rights proceedings based on a child's length of stay in foster care, but ASFA requires that a termination of parental rights proceeding be initiated when a child has been under the responsibility of the State for 15 of the most recent 22 months, it is believed that a child would be seriously endangered by returning home, or a child has been abandoned. The State may opt not to initiate a termination of parental rights proceeding when a child is living with a relative, a compelling reason suggests that initiating a proceeding would not be in the best interest of the child, or the State has not provided necessary services to the family.

ASFA reduced the time allowed to resolve cases of child maltreatment from 18 to 12 months. However, the U.S. Department of Health and Human Services (DHHS) report to Congress warned about problems in implementing ASFA:

> ...the Adoption and Safe Families Act (ASFA), passed in November of 1997, requires that decisions regarding permanency for children who enter foster care are to be made within 12 months of a child's entry into care. This requirement creates a context of urgency around the provision of services to families with children in foster care that put special strains on the usual and customary course of substance abuse treatment plans. Communities have very limited time frames within which to offer reunification services (including substance abuse treatment, as needed) before alternative plans must be made for the child. And parents have the same limited time frames within which to demonstrate their readiness to provide a safe home environment for their children. These factors also make it critically important that child welfare workers be able to judge accurately whether a parent is making sufficient progress in his or her rehabilitation program to reasonably expect the child could be returned to the parent within 12 months or shortly thereafter.[2]

The law clarifies that workers may make reasonable efforts to place a child for adoption or with a legal guardian concurrently with reasonable efforts to reunify the child. In addition, ASFA places a much higher priority on adoption, as its title signals, by providing incentive funding for States that exceed prior numbers of completed adoptions and by providing technical assistance to States to meet adoption targets, although the law does not specify reunification targets. The emphasis on adoption is strengthened by a mandate of reasonable efforts in completing permanency plans, but not reunification plans.

The Act clarifies that a child's health and safety are paramount in decisions about his or her removal from, and return to, his or her home. It sets forth several conditions, according to which "reasonable efforts" to preserve or reunify a family are not required when a court determines that a child's health or safety would be endangered. Some, but not all, States added additional criteria for terminating parental rights and not requiring CWS to provide reasonable efforts to reunify the family. Some of those additional criteria have focused on the substance abuse issues among parents.

Ohio, for example, uses a shorter time frame than the federal legislation and allows termination of parental rights after two "failed treatment attempts." California has legislative language implementing ASFA that says that reunification efforts need not be made if the court has "clear and convincing evidence" that the "parent has a history of extensive, abusive and chronic use of drugs or alcohol and has resisted prior treatment during the previous 3 years or has failed to comply with treatment under a case plan on at least 2 prior occasions."

States' implementation of ASFA clearly demands a new level of cooperation between child welfare and substance abuse treatment workers. For example, a social worker would have difficulty deciding what "extensive, abusive, and chronic use of drugs" means without an assessment of a client's drug and/or alcohol problems. Many States have not yet clarified these protocols and interagency roles in implementing ASFA. Several States have passed legislation but do not yet have either specific interagency agreements or information systems to verify whether the objectives of the new ASFA-enabling legislation are being met.

ASFA also demands a new level of consensus among courts and both child welfare and substance abuse treatment agencies, since the courts' interpretations of this language are also critical to ASFA's implementation. Agencies need to define "clear and convincing evidence" that a parent is resisting treatment by deciding, for example, whether this includes the substance abuse treatment agency's monthly report, an unsuccessful discharge, or a social worker's interview.

In the sites that have made the most progress, these questions are being addressed. However, few have yet developed and implemented firm responses. Noncompliance with ASFA is the norm more often than well-developed changes in practice. Considerable skepticism marks some longstanding child welfare advocates. As a compendium of articles on the future of child welfare said, "Members of the child welfare community are rather conflicted about ASFA's relative benefits and disadvantages."[3] Moreover, ASFA

> Means that parents who cannot resolve the problems that led to placement within 15 months, as is common for parents who are substance abusers and require at least 18 months treatment, are at risk of having their parental rights terminated, no matter what the age of their child or the degree of attachment between parent and child.[4]

An alternative interpretation of ASFA, voiced by many of the child welfare professionals consulted for this report, is that the requirement that parents demonstrate progress in 12 months, rather than "resolving the problem" in 15 months, is fair and appropriately child centered. However, this requires that the substance abuse treatment services and the child welfare timetable be adequately linked.

ASFA has unquestionably raised the stakes for collaboration, and the States and localities that have responded best have started taking interagency collaboration to a new level. These sites are addressing the demands of ASFA for:

- Closer agreement on shared outcomes among courts, substance abuse treatment agencies, and child welfare agencies;
- Working definitions of the language about reasonable efforts in State enabling legislation;
- Information and substance abuse treatment monitoring systems that can report on clients' progress;
- Timely access to substance abuse treatment that responds to the 6-12 month timeframes for termination of parental rights; and
- Training of both substance abuse treatment and child welfare workers in the requirements of ASFA.

In these sites, ASFA has been cited repeatedly as the stimulus for new dialogue among courts, child welfare, and substance abuse treatment agencies. States and localities have developed estimates of the number of children in out-of-home care who fall under the new time limits and, in some cases, have allocated new staff to bring placements into conformance with the law.

ASFA and Prenatally Exposed Infants

A recent article addresses, in depth, child welfare agencies' and courts' responses to births in which substance exposure is detected through toxicological screening.[5] Three of the most recent reports on ADS-CWS issues failed to address the policy options needed to respond to the difficult issues of substance-exposed infants. According to various States' laws, a positive screen can result in an automatic child protective service (CPS) referral and an automatic child abuse report, a referral made to a maternal and child health agency, or no action is formally required by State law. Prenatal exposure is discussed in chapter XII of this report.

The Essential Roles Played by Other Systems

ASFA is not the only legislation being implemented at the State and local level that affects substance abuse among families. Substance abuse is pervasive in its impact on children and families, and it co-occurs with other problems and is affected by several other programs. An overemphasis on a bilateral relationship between child welfare and substance abuse

Substance abuse has a pervasive impact on children and families. It co-occurs with other problems and is affected by several other programs.

treatment agencies ignores the complexity of clients' lives and the categorical systems constructed to respond to families' problems.

An overemphasis on bilateral relations between child welfare and substance abuse treatment agencies ignores the complexity of clients' lives and the categorical systems constructed to respond to families' problems.

TANF has had an obvious impact on many substance-abusing parents in the child welfare system, and several studies have assessed the initial lessons of TANF as it affects welfare clients with substance abuse problems.[6] Domestic violence, mental health, early childhood development and child care, the education system, and the juvenile justice system all have an unavoidable connection with substance abuse and child welfare clients.

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III. INNOVATIONS IN CHILD WELFARE PRACTICE

To work effectively with clients referred from child welfare agencies, substance abuse treatment agencies need to understand the state of good practice in those agencies. Recent years have seen a variety of changes in how front-line workers handle clients in the child welfare system. These include:

1. Family group decision making models;
2. Expansions of kinship arrangements;
3. Expansions of independent living programs for foster youth;
4. Concurrent planning and the press for adoption;
5. Informal supports (family and community), child welfare's community partnerships, and the family support movement, including family resource centers;
6. Differential response in case planning;
7. Home visiting;
8. Expanded use of child welfare outcomes; and
9. Stronger links between child welfare and welfare.

Each has an effect on the treatment needs of child welfare clients that is described below.

Family Group Decision Making Models (FGDMs)

Family group decision making models (FGDMs), known as "family group conferencing" in some sites, empower families in the child welfare system by making them active members of the case planning team in family group decision making; families identify their service needs and workers from agencies that can meet those needs attend periodic case conferences. This approach has been adopted in several States and some county-run systems.

Substance Abuse Treatment Implications

Some observers of FGDMs have raised questions about their implementation and potential impact on substance abuse issues:

- Families' issues with alcohol and drugs are not always addressed in family conferences because families do not identify them as problems, which is not surprising since the mechanism of addiction includes denial;
- The needs of younger children are underemphasized because they do not participate in the process; and
- The interagency consultation and information-sharing process needed to make family conferencing effective may, at times, be inadequate, resulting in insufficient information about a family's needs.

None of these concerns invalidates the very real contributions of this approach. However, each needs to be addressed if family conferencing is to avoid becoming another "reform du jour" that is unfairly discredited because it is subject to unrealistic claims. As the Miami and Cuyahoga County case studies make clear, if addiction specialists are built into the team from the outset, these problems can be minimized.

Expansion of Kinship Arrangements

The use of kinship arrangements has been expanded by a hard-pressed child welfare system to find homes for children whose parents are coping with substance abuse. Kinship care tends to be used less often with infants and teenagers, as most infants are placed in foster homes and most teenagers in foster or group homes.

Nationally, in 1997, 29 percent of all children in foster care—approximately 200,000—were in kinship care.[1] This represents a significant expansion of kinship placements and is explained in the Report to congress on Kinship Foster Care:

> Three main factors have contributed to this growth. First, the number of non-kin foster parents has not kept pace with the number of children requiring placement, creating a greater demand for foster caregivers. Second, child welfare agencies have developed a more positive attitude toward the use of kin as foster parents. Today, extended family members are usually given first priority when children require placement. Third, a number of Federal and State court rulings have recognized the rights of relatives to act as foster parents and to be compensated financially for doing so.

Substance Abuse Treatment Implications

Substance abuse treatment agencies will readily recognize the risks of kinship arrangements; because substance abuse is a family-transmitted disease, extended family members may also have substance abuse problems and therefore be unable to provide a safe and nurturing home. Grandparents, aunts and uncles are the primary caregivers of several million children with a significant percentage of these children in homes in which familial substance abuse problems exist.

Screening for kinship arrangements typically focuses less on substance abuse than seems appropriate in light of the intergenerational nature of the disease. Those responsible for substance abuse screening and assessment must be at least as vigilant in reviewing kinship arrangements as they are for nonrelative care. Kinship arrangements clearly require supportive services to train caregivers in providing children with the environmental stimulus and nurturing needed to produce positive outcomes.[2] This point is highlighted in the discussion of the Miami drug court (chapter X).

Expansion of Independent Living Programs (ILPs)

The Foster Care Independence Act of 1999 (public law 106-169) provides expanded services to foster care youth aged 15 years or older. This legislation provides $270 million over 5 years to increase funding for the Independent Living Program (ILP), which assists the nearly 20,000 young people who leave foster care each year at the age of 18 years without an adoptive family or permanent home.

Substance Abuse Treatment Implications

ILPs include a wide range of efforts to prepare youth for work, higher education, and living on their own. Some programs include substance abuse prevention curricula, but many do not address these issues in depth, despite the known potential for substance abuse of youth in foster care whose families have substance abuse problems. Substance abuse treatment and prevention agencies can work with ILP providers (which often include community colleges and other training institutions) to offer training programs and workshops on substance abuse prevention and treatment that are relevant to older youth in foster care.

Concurrent Planning and the Press for Adoption

Concurrent planning, based on the commitment to permanency for children in the child welfare system, seeks the simultaneous development of a plan for reunification services and a plan for timely legal permanency for children in out-of-home care. Spurred by the ASFA time limits, concurrent planning requires more rapid judgments about families' readiness for reunification and broader recruitment of long-term foster and adoptive families. In spite of the promise of concurrent planning, few practice models have been documented in the literature.[3]

Concurrent planning has been most fully implemented in Washington State, where:

> The extra value in concurrent planning lies in the training and preparation that permanency planning families receive, and the clearly defined goals/expectations that the agency communicates to birth parents. From the very beginning, each foster/adoptive family is prepared to be an agent of stability in the child's life and serve as a bridge to the birth family. Birth parents benefit from the family connection, and as a result of the relationships forged between birth and foster families, birth parents who do not reunify are much more likely to voluntarily relinquish their children and enter into an open adoption agreement. With the help of the agency, the child's two families can often work out an optimal plan that serves everyone's interests.[4]

Substance Abuse Treatment Implications

As with all these ASFA-related reforms, a premium is placed on close communications between substance abuse treatment providers and child welfare agencies, so that decisions about adoption or reunification are made with full information about the progress made by the parents.

Concurrent planning presumes that services have been made fully available to the birth parents, which requires resources from the substance abuse treatment system for parents. The close links with courts and mental health and substance abuse treatment agencies has been described as critical to deciding whether reunification or adoption is the right outcome for the child.[5]

Informal Supports, Community Partnerships, and Family Support

Another reform involves greater response from community members to lower risk incidents of reported abuse and neglect, because child welfare agencies alone cannot respond to all cases of abuse and neglect. Moreover, communities have a responsibility to respond to families with both formal resources and informal support. In this approach, child protective services (CPS) serves as a special child welfare service (CWS) that investigates allegations of child abuse and neglect and provides services to children and families when abuse and neglect have been confirmed. The child welfare system should offer housing, employment, and utility assistance to prevent families from entering the CPS because such needs are not met.[6]

Community partnerships for the protection of children have been developed in a number of sites, with grassroots groups and community residents serving as active participants in defining problems and developing solutions. Family support programs, including family resource centers, have been part of some of these partnerships, using Family Preservation and Support funding (renamed Promoting Safe and Stable Families in ASFA). Some community partnerships are also linked with the differential response reforms described below. Most of these programs, however, underemphasize substance abuse content in the parent education and family support programs.

Substance Abuse Treatment Implications

Some community partnerships have done a good job of addressing substance abuse as one of a complex set of community conditions through forums for community members, CPS staff, and treatment providers to work together in prevention and early intervention services. In the Jacksonville case study, initial contacts among community organizations, CWS, and substance abuse treatment agencies were made in the Clark Foundation-sponsored community partnership.

The challenge to substance abuse treatment agencies is to provide enough information in a community-based process to allow participants from a wide variety of agencies to recognize the importance of substance abuse treatment issues in families in the CWS system. Communities should not be satisfied with small projects, but, rather, should fully address the critical role played by substance abuse in creating positive or negative community conditions, and seek resources to respond appropriately to these problems.

Differential Response in Case Planning

A related set of reforms emphasizes differential responses to child abuse reports in an attempt to develop

> ...a customized response, depending upon each family's needs and strengths, [sharing] responsibility for child protection with a wide range of partners in the community, including criminal justice, other public agencies, private agencies, individuals, and families....In a differential response system, other partners in the community will have an explicit, agreed-upon role to play in protecting children. On high-risk cases, CPS will retain primary responsibility for assuring children's safety but will team with community partners on a case-by-case basis. On lower-risk cases, non-CPS partners will have primary responsibility for working with the family and will provide services on a voluntary basis.[7]

In Florida, Missouri, Kentucky, and Iowa, progress toward differential response has been made, and community partnerships are a major feature of these reforms.

Substance Abuse Treatment Implications

Differential responses assume that substance abuse treatment agencies are one community partner serving families reported to CPS, but how community agencies implement this response is not always clear. To some extent, this exemplifies the one-way approach, in which CWS agencies state the need for substance abuse treatment services without developing the reciprocal relationships, mutual benefits, and shared resources needed to effect a real partnership.

Discussions of these reforms rarely address monitoring substance abuse treatment and parent education agencies, the two most frequent referrals made by CWS. In addition, little attention has been paid to the need to shift funding from the least effective to the most effective of these agencies, and in making the investments needed to find out how to tell the difference.

Home Visiting

A growing concern abut earlier interventions for younger children has led to several reviews of the experience of home visiting models,[8] which provide in-home support services to families identified as at risk based on several indicators, including poverty, single parenting, a lack of access to regular health care, and, less frequently, documented substance abuse. Several national models of home visiting programs have been published by Federal and private funders.[9] Some of these models are triggered by CPS reports that, while not serious enough to merit removal of the children, are judged to require a continuing response by service providers.

Substance Abuse Treatment Implications

Substance abuse treatment issues arise in home visiting through: (1) the factors used in the original screening for risk, such as substance-exposed births; and (2) the extent to which substance abuse issues are addressed formally or informally in the protocols for the services to be provided by home visiting staff, such as employing staff who are familiar with the recovery process.

Expanded Use of Child Welfare Outcomes Indicators

In a linked set of projects, several national organizations have developed a framework to address child welfare outcomes and indicators in response to the current state of the art in outcomes measurement, managed care, and the references in ASFA to the need for expanded outcome measurement of the effectiveness of child welfare agencies and systems. The broadest of these is the Casey Outcomes and Decision Making Project, a project of the Casey Family Program, the Annie E. Casey Foundation, the American Bar Association, and the American Humane Association.[10] This project has developed an outcomes matrix that can be used by child welfare agencies in managed care environments. Two of the 23 indicators in the matrix are directly related to substance abuse issues: "child is drug and alcohol free" and "caregiver is drug and alcohol free." However, the tools used to make these assessments are not described.

Substance Abuse Treatment Implications

Thus far, these materials have not addressed the parallel issues in managed care of alcohol and drug treatment, which has tended to under emphasize the need for longer term services and aftercare to parents with children in the CWS system. Many managed care behavioral health systems are unwilling to cover adequate substance abuse treatment services, and this needs to be addressed by the development of managed care outcomes in CWS.[11]

Stronger Links Between Child Welfare and Welfare

In a widely publicized model of child welfare reform, El Paso County, Colorado, has combined child welfare and welfare programs by using Temporary Assistance for Needy Families (TANF) as an antipoverty program and declaring reduction of poverty as the county's policy goal, rather than reduction of welfare rolls.[12] This reform uses TANF funds for preventive services for the child welfare population. California and North Carolina State officials have reviewed these reforms and are considering how to implement them; at least one foundation interested in child welfare innovation has launched some demonstration projects to test the concept at the county level. Local officials in Colorado note problems operationalizing the reduction of poverty and, at present, no outcomes measures have verified that this is actually occurring.

Substance Abuse Treatment Implications

Several studies have documented the correlation between child neglect charges and substance abuse, especially alcohol abuse. The El Paso reform, which uses a managed care model of substance abuse treatment services for the child welfare and welfare populations, has not yet used the combined approach to child welfare and welfare.

Conclusions on Child Welfare Reforms

As general responses to the need for greater comprehensiveness, community involvement, and help for hard-pressed CWS agencies, these are all laudable reforms. However, the extent of their focus on alcohol and drug services (ADS) varies widely, and all would benefit from more in-depth discussions of how and why substance abuse prevention and treatment agencies should be more involved in these reforms.

Case Studies

The State and local models selected for this report are richer than the models identified in 1997-98. Several have emerging data on the impact of these innovations on clients. Each of the 10 critical elements of the framework developed for assessing the seven sites must be attended to in developing sustained links between child welfare and substance abuse treatment services. The case studies are organized according to these categories because they are the best way to describe and analyze the complicated interactions between different aspects of each site's model.

These 10 elements are both distinct and interdependent. The daily practice items are, perhaps, most crucial because in the strongest sites, the relationships among staff on the front line have been fundamental. These staffs work together very differently than their counterparts in most agencies; they function as closely linked parts of a network with multiple connections, but one unifying goal—to move clients into and through treatment, while paying full attention to the needs of their children. These core relationships among staff are the essential ingredients of change, without which the other elements will have little impact on practice.

> *The sites have a unifying goal: to move clients into and through treatment, while paying full attention to the needs of their children.*

None of the seven sites is currently addressing all the reforms discussed in this chapter, or working simultaneously on all 10 elements in the framework. Trying to achieve all of the reforms at once could undermine the credibility of reform by innovation overload on hard-pressed systems. But these seven sites do exemplify promising practices to address specific barriers. In doing so, they show other States and communities how to expand on prior efforts. They may also help new sites determine which reforms to undertake.

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IV. THE STATE OF CONNECTICUT'S PROJECT SAFE

Background and Project Description

Project SAFE (Substance Abuse Family Evaluation) started in Connecticut in 1995, in response to the widely publicized death of a child in the custody of the Department of Children and Families (DCF). The death was followed by an extensive review requested by the governor, which found that substance abuse was a contributing factor and that DCF was not systematically screening for substance abuse.

As its name suggests, the primary purpose of Project SAFE initially was to respond to and evaluate families' substance abuse for decisions about removing children from their parents' custody and evidence in court hearings. Workers and policymakers wanted a clinical tool for initial screening, substance abuse assessment, and monitoring client prognosis.

DCF is responsible for child welfare and children's mental health, juvenile justice, and adolescent substance abuse treatment programs in Connecticut. It instituted a substance abuse screening questionnaire for use by child welfare workers throughout the system. The screening tool (appendix 4-1) was used to "screen in" parents and potential caregivers for further assessment. DCF contracted with a newly formed nonprofit organization, Advanced Behavioral Health, Inc. (ABH), a statewide consortium of nonprofit behavioral health agencies, to conduct the assessments on a fee-for-service basis.

ABH initially provided drug testing, substance abuse assessments, and outpatient substance abuse treatment to biological parents and caregivers referred from the abuse and neglect investigations and/or ongoing services programs. Foster parents being evaluated to assume legal guardianship status and others were later added to the program. Project SAFE services now include drug testing; assessment; individual, group, and family counseling; and intensive outpatient and partial hospital treatment. By November 1999, DCF had referred over 23,000 unduplicated individuals to the program.

ABH network providers are reimbursed for substance abuse services through the State's Medicaid program. Clients and services not covered by Medicaid (e.g., longer term residential programs) are provided through the publicly funded treatment system managed by the State's Department of Mental Health and Addiction Services (DMHAS).

Phase I of Project SAFE focused on ensuring immediate access to substance abuse evaluations and outpatient services for DCF parents. DCF subsequently placed substance abuse counselors in the DCF regional offices.

The lessons learned during phase I and the Adoption and Safe Families Act (ASFA) imperatives led to shifts in philosophy and operations in Project SAFE. By mid-1999, DCF recognized the need to form a closer relationship with DMHAS, which is responsible for services to persons with alcohol- and drug-related problems, to better tap into existing publicly funded assessment and treatment resources—both funding and expertise.

Phase II of Project SAFE began with the development of 15 guideposts for collaboration between DCF and DMHAS (appendix 4-2) and the organization of a working group in 1999. The working group developed a strategic plan for phase II, and drafted a client-based treatment model to respond to the full range of issues that arise during a substance abuse treatment episode and a family's involvement with child protective services (CPS). The model addressed clearer priorities for the child welfare population; strategies to improve treatment engagement, retention, and completion; individual client and family outcomes; and budgeting and funding mechanisms.

Underlying Values and Principles

While Project SAFE began as an effort to document the extent of substance abuse in the DCF case files, by 1999, DCF and DMHAS had developed a common vision of working together to serve the families needing services from both agencies. The 15 guideposts that form the basis of their common principles were drafted by the deputy commissioner of addiction services and then approved by the commissioners of both departments. The guideposts became the basis for the strategic plan.

As a direct result of the time and energy devoted to developing the phase II collaboration, the partnership between DCF and DMHAS has come closer to achieving truly shared responsibility than any of other sites studies for this report.

Daily Practice—Client Intake, Screening, and Assessment

Phase I of Project SAFE focused primarily on client intake, screening, and assessment. DCF and ABH staff created and revised the screening tool process and data collection system that DCF workers use to determine if a parent should be referred for further substance abuse assessment. A positive response to any one of the screening tool's 13 items results in a referral to ABH for drug testing and substance abuse assessment.

The screening and referral process is as follows:

1. DCF worker administers the screening tool and/or makes behavioral observations indicating a substance abuse issue.
2. DCF worker calls an 800 telephone number to refer client to ABH.
3. ABH staff collects information regarding the client and enters the information into the ABH information system.

4. ABH staff tells the DCF worker which ABH network provider will receive the referral information and schedules an assessment appointment.
5. ABH staff faxes the referral information to the appropriate provider organization.
6. The treatment provider conducts the substance abuse assessment.
7. The treatment provider faxes results and sends a standardized report to DCF workers.
8. If the ABH treatment provider does not recommend substance abuse treatment, the substance abuse counselor telephones the DCF social worker to discuss the case.
9. If the ABH treatment provider recommends substance abuse treatment, the treatment provider reports to DCF on client's progress in care.

In addition to immediate access to substance abuse assessments, at least one substance abuse specialist is now assigned to each regional DCF office. For more difficult cases, regional specialists who are DCF employees now provide case consultation, intervention with specific families, and formal and informal training for DCF workers.

DCF caseworkers were willing to change their daily practice because they saw a direct benefit in handling the case, and did not regard it as merely more paperwork.

DCF workers gradually came to accept the requirement to conduct the screening and house the substance abuse specialists in their offices. Policymakers now say that they could not take the substance abuse specialist away from the social workers, even if they wanted to. Social workers came to see the additional work involved in communicating with ABH and the regional specialists as helpful to them—an added value, not an added burden. One policymaker said that social workers "began to accept the regional specialist because the specialists made sure that the DCF social workers became their clients." As one worker put it, "It's a godsend. I don't feel that I have to know everything, like when and who to hair test. I can go to [the regional specialist] for advice."

DCF workers appreciated that the program required only gradual, not sudden, changes in attitude and behavior."Stability and change are not inconsistent," said one official.

Daily Practice—Client Engagement and Retention in Care

Each point at which clients are likely to stop treatment must be addressed with specific corrective action.

Connecticut has invested significant resources in developing a client-based information system and documenting the dropoff rates (rates at which clients stop treatment) at different points throughout the system. These data have led to a greater emphasis on retention in treatment than in many other programs that have linked child welfare services (CWS) and substance abuse services.

Project SAFE has compiled 5 years' worth of data on client characteristics and treatment evaluation results from more than 5,000 completed assessments through1999. A review of this database revealed a 46 percent treatment completion rate for clients who entered treatment. The first 5 years of experience with the model made clear the need for immediate engagement and pretreatment models:

Key Data for Project SAFE, 1995-1999		
	N	% of DCF cases
Clients referred to ABH services in FY 1999	5,776	~50
Evaluations performed	5,102	88
Clients referred for treatment	2,736	53
Clients who went to treatment	1,134	41

Over the past few years, DCF has instituted changes in the model and conducted several innovative pilot projects to increase the show rates for evaluation and treatment. For example, a pilot project in Manchester using motivational enhancement therapy to mobilize the client's own change resources looks very promising. A pilot project in Hartford used targeted outreach methods to dramatically increase the show rate for treatment. Of the 55 clients in the outreach experimental group, 47 clients (85 percent) kept their first treatment appointment, compared to 25 clients (44 percent) in the control group.

In planning phase II of Project SAFE, DCF, and DMHAS recognized the need to change the screening and assessment protocol to improve retention rates. As a result, phase II includes screening for barriers to treatment engagement (e.g., transportation, childcare, and healthcare needs that impede treatment engagement and completion). In addition, protocols include assessment of three primary domains in the early engagement process: risk to the child, severity of the alcohol and drug problems, and treatment readiness.

Daily Practice—Services to Children

A study of the Project SAFE client caseload revealed that a substantial proportion of parents in the program had children for whom prevention activities were needed. DCF has established services for these children of substance abusers (COSAs) at school and other community-based sites. DMHAS is one of the few statewide alcohol and drug agencies to establish group interventions for COSAs in each region, including, most recently, culturally specific COSA groups. In 1998, the Substance Abuse and Mental Health Services Agency (SAMHSA) funded DMHAS to participate in SAMHSA's national cross-site study, which focuses on the effectiveness of prevention interventions for COSAs. Essential program elements for the SAMHSA study include parents and youth learning together, programs designed for use with ethnically diverse families in rural and urban settings, and use of program models that have been scientifically evaluated and shown to be effective.

Joint Accountability and Shared Outcomes

The 1999 review of phase I and plans to improve the program included extended discussions of the program's overall outcomes. As DCF and DMHAS strengthened their partnership to respond to the phase I results, they leveraged the partnership to implement a clinical service model focused on improving client outcomes. These outcomes included improving treatment retention and completion rates, increasing attention to the mental health and trauma needs of families, and ensuring that appropriate funding mechanisms were used to sustain the clinical model. The resulting outcome goals include improving:

- Show rates for substance abuse evaluations after a referral by DCF,
- Show rates for substance abuse treatment after a referral to treatment by a substance abuse provider,
- Engagement and retention of clients in substance abuse treatment,
- Rates of completion of clients' substance abuse treatment plans,
- Child safety, and
- Family functioning.

Information Sharing and Data Systems

Project SAFE's database has provided staff with more detailed information on its clients' substance abuse problems and progress in treatment than most other sites examined in this review.

Of particular importance is the ability to crosslink the ABH and DMHAS datasets, yielding over 2,500 Project SAFE clients in the DMHAS client information collection system dataset. A comparison of the DCF population to the overall DMHAS population revealed several substance use patterns and characteristics in DCF clients, including the following.

An early focus on information systems has allowed policymakers to address the practice and policy implications of differences between parents referred by DCF and the overall DMHAS population.

Project SAFE clients are much more likely to report marijuana use (45% of men and 39% of women) than the general treatment population (21% of all clients reported marijuana as a problem);

- Project SAFE clients are less likely to report heroin use (9% of men and 12% of women) than the general treatment population (48% of all clients reported heroin as a problem);
- There were differential treatment completion rates based on the use of specific substances; among clients reporting primary alcohol problems, 39% terminate treatment compared to 41% of clients reporting marijuana, 44% of clients reporting cocaine, and 50% of clients who report a primary heroin problem;
- For clients who report a single problem substance, percentages of treatment terminations are lower; 35% of clients with an alcohol problem and 35% of clients reporting a heroin

problem, 38% of clients with a primary marijuana problem, and 42% of clients reporting cocaine problems unsuccessfully terminated treatment; and

- Clients who report both cocaine and marijuana problems have the highest rate of treatment terminations (53%) compared to 44% of clients reporting either alcohol and cocaine or alcohol, cocaine, and marijuana, and 39% of clients reporting alcohol and marijuana who terminate treatment.

The alcohol and drug use pattern among DCF-referred women has required DMHAS and DCF to review their treatment strategies and programs for women and their children.

Training and Staff Development

Project SAFE has made a major commitment to training its workers, and provides all new DCF workers with 3 days of substance abuse training that includes motivational interviewing techniques and addresses the differences among different drugs and different clients, such as parents and adolescents. ABH staff also meet with new workers to discuss what happens when they make a referral.

Ongoing staff training must be mandatory, prescheduled, and repeated.

Crosstraining is provided through regional meetings with substance abuse treatment service providers and CPS staff. The DCF regional substance abuse specialist was instrumental in organizing meetings, and workers report that the informal discussions of cases and system differences help them understand each other's attitudes and policies toward addiction.

Connecticut's experience suggests that training, in the words of one policy-level official, needs to be "mandatory, prescheduled, and offered more than once." In addition to the formal orientation, numerous *ad hoc* sessions focus on specific topics. Equally important training is provided through the more informal on-the-job crosstraining that results from true outstationing and colocation: "We learn each other's jobs and see each others' perspectives on the system and the clients."

Budgeting and Program Sustainability

DCF and DMHAS have assembled a wide array of funding sources, but have not yet tapped all that are available. Increased State funding of DCF services resulted in part from the intense spotlight on the child's death in 1995. But other funding sources also support Project SAFE:

- Contracted substance abuse providers who serve clients requiring more intensive services than outpatient care are supported through the DMHAS grant from Federal block grant and State-appropriated funds.

- The 45 percent of Project SAFE clients who are eligible for Medicaid must receive services in accordance with medical necessity criteria established by the contracted health plans of the department of social services.
- Eligible clients receive services through the DMHAS general assistance program.

These different contract and revenue sources for substance abuse treatment have their own eligibility criteria, funding mechanisms, information system requirements, and contract administration with the providers. The various funding and eligibility criteria create additional layers of subsystems that must be negotiated and coordinated by the DCF regional substance abuse specialist, the treatment provider, and, most importantly, the client.

Some officials regard the reliance on Medicaid managed care for many DCF parents as creating complexity in the system. The State uses three different insurers, which complicates the funding system for providers and DCF case managers seeking appropriate services for their clients. In particular, officials note that fee-for-service contracts do not allow treatment providers to be paid if clients do not keep their appointments, even though the programs incur staff-related costs. The medical necessity criteria used by managed care companies may not account for the social and environmental needs of the families involved with DCF. Funding shortages are believed to present a significant barrier for such services as transportation, respite care, and childcare. DCF and DMHAS are planning a resource development strategy for the longer term to fill some of these gaps.

Working with the Courts

For the court process, Project SAFE documents that treatment has been offered, whether or not the parent has responded, and how to make the reunification decision based on the parent's response. As a staff member noted, "The assessment helps structure the case so when we go into court, we know what we are talking about."

Project staff point out that some courts are becoming more interested in a client's demonstrated behavior as a real outcome of substance abuse treatment, rather than simply monitoring the number of days spent by a client in treatment. However, some courts still insist that one "dirty test," i.e., one positive urine screening for drugs, is cause for permanent removal. Other courts have mandated a different number of drug tests or a certain level of detail in reporting on clients' progress. A lack of uniformity among different judges can create problems in some areas. Training for judges is planned for the future.

Working with Related Agencies and the Community

For some clients, returning from treatment to the community may make relapse more likely.

Finding licensed childcare for the children of parents in day treatment programs has been difficult. Navigating the complex childcare system, especially as it interacts with Temporary Assistance to Needy Families (TANF) childcare eligibility and licensing requirements, can be too time consuming for child welfare workers. While many of the children may need special treatment-oriented services as well, simply obtaining the childcare arranged can prove difficult. DCF and DMHAS regard these issues as directly affecting clients' tendency to relapse, and as a symptom of community services breakdown. In phase II, Project SAFE leaders plan to address the full range of supportive services needed, including housing, transportation, and economic self-sufficiency support.

Summary

The critical innovations in Connecticut include immediate substance abuse evaluations for DCF clients, DCF regional specialists with expertise in addiction services, and information systems able to document dropoff points to help improve retention.

Project SAFE is a model program because the staff of two agencies have devoted significant resources to assessing the model's problems and redesigning their linkages to be more effective. The focus is on self-assessment, as evidenced by the plans for phase II that emerged from the strategic planning exercise, and on a commitment to work with other groups that can provide information about other models around the Nation and, thus, raise expectations.

V. NEW JERSEY'S CHILD PROTECTION SUBSTANCE ABUSE INITIATIVE

Background and Project Description

In 1995, the State of New Jersey initiated the Child Protection Substance Abuse Initiative (CPSAI) through the Department of Human Services, Division of Youth and Family Services (DYFS), the State agency responsible for child welfare and child protection services (CPS). The impetus was the finding that an estimated 80 percent of the State's child welfare cases involved substance abuse, based on a review of child welfare cases from 1992 to 1994 that was funded by the National Center on Child Abuse and Neglect (NCCAN).

CPSAI is an assessment, referral, and case management service that identifies the level of risk of harm to the child posed by the parent/caregiver's substance abuse. Its mission is to promote child protection by identifying cases involving substance abuse and obtaining treatment for the substance abuser; reunification of children and parents is a secondary outcome. When a report is made to DYFS, a CPS caseworker can request that a substance abuse counselor conduct an assessment. If the counselor determines that substance abuse is a factor in the case, the caseworker and counselor produce a joint service plan for substance abuse treatment, assign a home visitor to monitor the parents' compliance with treatment, and make referrals to other social services. The caseworker is responsible for the joint service plan and for conducting standard CPS procedures.

CPSAI was initially piloted in four cities. A statewide contract agency provided the certified alcohol and drug counselors (CADCs) and paraprofessional home visitors, who were outstationed in DYFS district offices in the pilot cities. To expand the initiative in 1996, DYFS and the Department of Health and Senior Services, Division of Addiction Services (DAS), developed a memorandum of agreement to increase bed capacity for women substance abusers. DYFS and DAS agreed to provide priority treatment access to mothers of DYFS-supervised children. CPSAI was expanded in 1998 to provide services in all DYFS district offices and adoption centers.

As of the spring of 2000, 31 CADCs and 37 home visitors had been assigned to work with DYFS. Each CADC conducts approximately 20 assessments per month, and each part-time home visitor carries a caseload of 10 families.

Underlying Values and Principles

CPSAI was based on the need of DYFS workers for help from qualified addiction services professionals. In their early discussions, both DYFS and the contract provider recognized the need for changes in their basic methods of approaching clients. DYFS workers realized that the child's well-being was ultimately best served by helping a parent recover. Substance abuse counselors, who ordinarily wait for referred clients to come to them, recognized the need to seek out and engage clients with home visits. All district offices are now committed to the program; some have even hired additional alcohol and drug counselors using their own funds.

At the time of the site visit, the impact was not clear of the new ASFA time lines on the overall caseload and the filing of court petitions to terminate parental rights. However, some staff believed that the shorter time lines increased the urgency for clients to comply with treatment, and some judges were less tolerant of substance abuse relapse and noncompliance with family case plans. Termination of parental rights procedures are filed after the initial 14 months of the case under the new law, resulting in a recent increase in total termination of parental rights filings. As with the other sites, relapse or failure to comply are challenges for CPSAI.

The use of addiction service professionals with life experience in addiction issues has been a major asset to the program.

Daily Practice—Client Intake, Screening, and Assessment

DYFS intake workers provisionally rate the child abuse reports they receive according to the severity of risk to the child. If a case appears to involve substance abuse, DYFS staff refer it to the local DYFS-contracted provider of alcohol and drug counselors (see appendix IV-A for the referral, consent, and clients rights forms). A counselor and the DYFS intake worker meet the client at home, in the hospital, or elsewhere outside of the DYFS offices. One worker explained, "You see the drugs there, the deals are going on, and the client is less likely to try to manipulate the worker as might happen in an office setting." The alcohol and drug counselor administers a substance abuse evaluation and the intake worker gathers information about child maltreatment. These assessments occur within 24-72 hours to determine the severity of substance abuse and the level of care needed.

The child protection caseworker and substance abuse counselor use the following screening and assessment tools:

1. The CAGE screen is used for alcohol and drug screening. CAGE consists of four questions about efforts to decrease use, criticisms for substance use, feelings of guilt about using, and increasing use to recover from the bad effects of previous use.
2. The American Society of Addiction Medicine patient placement criteria and the *Diagnostic & Statistical Manual of Mental Health Disorders IV* (*DSM-IV*) are used to determine appropriate levels of care for clients.
3. The Triage Assessment for Addictive Disorders (appendix V-B), a brief, structured interview, is used to identify obvious cases of substance abuse and provide substantial support for a psychiatric diagnosis based on the *DSM-IV*.
4. Finally, the DYFS comprehensive biopsychosocial interview determines the impact of the client's addiction on different life domains and the likelihood of risk to the children (appendix V-C).

If the assessment shows substance abuse or dependency, and children in the home are 6 years of age or younger, the case is categorized as high risk.

The caseworker and the counselor then develop a joint service plan that includes a referral to substance abuse treatment, assignment of a home visitor, and any needed support services. The home visitor, a person in recovery, sees the parent within 24 hours of the assessment. The treatment program furnishes progress reports to the alcohol and drug counselor twice a month, and the counselor notifies the DYFS worker about contacts with the treatment programs.

DYFS workers find that having outside contractors conduct the assessments helps resolve conflicts about the treatments to recommend, and the report of a neutral, trained third party may carry more weight in court.

Daily Practice—Client Engagement and Retention in Care

To address client resistance, DYFS produced a videotape of six former clients whose children had been removed by DYFS at least once. Now in recovery, the parents eloquently say that DYFS helped them do what they could not have done alone—become better parents. The video has been distributed widely and is used to train DYFS social workers.

Video Used as Client Engagement Tool: The New Jersey staff have developed a video featuring parents who are former clients of DYFS as a training and client engagement tool.

DYFS has tried to improve linkages and retention by contracting with longer term, comprehensive providers, including Seabrook House in southern New Jersey, which stresses understanding the child welfare system, uses a multidisciplinary team, and provides follow-up as part of case management. Seabrook House is an example of New Jersey's emphasis on effective linkages between DYFS and treatment agencies, as it provides a therapist for drug treatment and a case manager to interface with DYFS and other agencies. Seabrook House also provides case conferencing with DYFS and mental health agencies, and follow-up services for 2 years.

Seabrook House staff made it clear that the clients they serve, many of whom grew up on welfare, require services well beyond substance abuse treatment. One worker said, "We try to do in 1 year what should have been done in the first 18." The case manager's efforts to connect clients with additional services are especially helpful for this population and increase their chances of success.

DYFS and DAS have expanded treatment through additional treatment slots for DYFS families, as specified in their memorandum of understanding, and extended the length of treatment authorizations from 28 to 90 days. The agencies contract with their providers for the longer treatment stays.

Daily Practice—Services to Children

Children receive mental health, health, and related social services as part of the family services provided by DYFS. In addition, the CPSAI home visitors are trained to help parents with parenting issues by modeling appropriate discipline techniques. The home visitors also make referrals for children's supportive programs (e.g., Head Start, educational assistance, special advocate programs).

Home visitors have enabled the program to work directly with children of substance abusers.

Joint Accountability and Shared Outcomes

In 1999, DYFS referred over 7,000 clients to CPSAI; 5,600 of these were assessed for substance abuse. In its first 3 years, CPSAI served 75 percent of clients who needed treatment, but in the next 2 years, the program served only 50 percent of those needing treatment. Senior-level department staff believe this decrease to be the consequence of accepting more challenging cases, a change in caseloads, and the different criteria used for reunification services under ASFA. Program leaders have set a goal of serving 90 percent of clients identified as substance abusers. While New Jersey has not assessed its dropoff points in detail, as the Connecticut program has, program leaders agree that the evaluation of the child welfare and substance abuse program outcomes needs to focus on client retention. Gathering outcome data will be a priority in the next few years.

Information Sharing and Data Systems

All clients sign confidentiality protocols and releases for the exchange of information among agencies. Staff indicate that no one has ever refused to grant consent, and no releases have been rescinded (see appendix V-D for the treatment progress report).

Training and Staff Development

As part of their 20-day orientation, new DYFS workers undergo 3 days of substance abuse training on indicators of high-risk addiction. Workers learn that they are not expected to assess or diagnose addiction, but to know when to refer clients to the CPSAI alcohol and drug counselors. The training also dispels common myths and preconceived notions about addiction.

CADCs also provide in-service training to DYFS workers statewide, including in-house seminars on an *ad hoc* basis and informal training. Home visitors benefit from 6 days of training. Efforts have been made to hire bilingual staff to serve the program's many Hispanic clients.

Budgeting and Program Sustainability

State agencies support the CPSAI through a variety of funding sources, including substance abuse and child welfare service funding, the State's family preservation funding, and Medicaid. The initial NCCAN funds have been supplemented with an additional State appropriation of $1.5 million to provide the CADC and home visitors. The State has also obtained funding from the Center for Substance Abuse Treatment (CSAT) to expand services to DYFS clients.

Working with the Courts

As in most sites, judges' understanding of and support for the CPSAI vary. Ultimately, DYFS hopes for more court involvement, which might influence clients' decisions to enter and comply with treatment.

Working with Related Agencies and the Community

Home visitors transport and connect clients with housing and primary healthcare. While doing so, they coach and encourage the clients, with therapeutic benefits.

This population has a strong need for safe housing; once clients begin recovery, their sobriety can be jeopardized by not having a safe place in which to live.

Summary

New Jersey's CPSAI protects children by identifying child abuse and neglect cases involving substance abuse and treating the substance abuser. The program has met its goals of obtaining services from CADCs and using home visitors to provide frequent contact and engagement with clients. The contract agency is a good example of using expert staff from nonprofit agencies to supplement the efforts of State staff in local field offices. Program staff have tempered client resistance to treatment through videotaped testimonies of former clients, better linkages to services, and more treatment slots. Goals still to be met include increased involvement with the courts and a systematic program evaluation.

VI. SACRAMENTO COUNTY'S
ALCOHOL AND OTHER DRUG TREATMENT INITIATIVE

Background and Project Description

Sacramento County's Department of Health and Human Services (DHHS) began, in 1993, to develop an innovative response to the growing number of child protective cases that involved substance abuse-related problems.[1] A system assessment showed that, on average, 2,000 drug-exposed infants were born annually, and anecdotal reports from the child protective services (CPS) division indicated that 70 percent of its caseload was affected by alcohol and/or drugs. Sacramento, one of 58 counties in California, has a population of approximately 1.2 million and admits approximately 4,500 clients to its alcohol and drug (A&D) division programs each year. The DHHS leaders found that the community could only meet approximately 25 percent of the A&D treatment needs of its child welfare families. In addition, most CPS clients were being referred to intensive levels of treatment, resulting in long waiting lists.

DHHS developed the Alcohol and Other Drug Treatment Initiative (AODTI), a multifaceted initiative to change the child welfare and other systems through training and making each worker responsible for A&D assessment and intervention. The clear and ambitious goal was to provide direct A&D treatment on demand. DHHS has now trained more than 4,000 staff members, including 1,500 DHHS employees.

AODTI developed specific procedures for CPS social workers to conduct A&D screenings and initial assessments. The new DHHS policy stipulated that every child welfare system include a comprehensive substance abuse assessment to rule out, or identify the severity of, the A&D problem as part of the risk assessment and case planning process.

From September 1996 through August 1997, almost 3,000 assessments (an average of 250 per month) were completed, with copies submitted to the AODTI evaluation office. However, in early 1997, the tragic deaths of two young children in the CPS system and the resulting public reaction led to significant increases in court petition filings and child welfare caseloads. As a result, social workers stopped completing A&D assessments in August 1997, and the number of assessments completed and submitted to AODTI staff dropped dramatically, to approximately 20 per month.

However, the new director of the A&D Services Division embraced the core values and goals of AODTI, and these principles became the foundation for the division's new system of care (SOC) approach. The approach included a standardized screening and assessment policy across county agencies, patient placement in the most appropriate level of care, outcomes monitoring and continuous program improvement, and treatment access priority for families receiving services in other county departments and, specifically, women reported to CPS with child abuse and/or neglect allegations. The new approach extended well beyond initial AODTI goals, while building on its values, activities, and information systems.

During the 6 years since AODTI was implemented, an extraordinary range of policy changes has affected the context in which it operates, including welfare reform; new Federal child welfare legislation; the selection of the county as a site for the Center for Substance Treatment (CSAT) outcome monitoring effort; and new statewide links among county-level A&D, mental health, and welfare department directors.

Underlying Values and Principles

AODTI was based on a core set of values from its inception. A formal statement of its values and working principles, developed in 1995, sets out this critical philosophy:

> Service priority should be given to those clients at greatest risk, which strongly argues that clients with children…should be seen among those at greatest risk because the children are also at risk.

The values and principles statement included:

- Prioritizing high-risk clients;
- Expanding treatment and support service capacity within existing resources, primarily by expanding group services with different foci (e.g., education and support, treatment readiness, brief intervention, traditional treatment groups);
- Viewing the client as an integral partner in a successful intervention;
- Increasing the staff's level of knowledge and understanding of, and sensitivity to addiction, recovery, and relapse; and
- Increasing the staff's ability to respond appropriately to problems associated with A&D use.

These basic premises explicitly recognize that most child welfare workers did not know enough about A&D abuse, while A&D treatment agency staff did not know enough about child protection and family systems. The goal was to enable both groups to work effectively across agencies.

The project's prioritization of CPS clients and county multisystem users helped the A&D Services Division formalize policies and procedures and allocate resources to expand capacity to respond to women. The value system and data helped sustain AODTI through the policy fluctuations during this period. The impact is reflected in the county's treatment access numbers: women receive only 35 percent of available treatment resources in California, but 52 percent of resources in Sacramento County.

Daily Practice—Client Intake, Screening, and Assessment

Using screening and assessment tools with CPS clients was an initial, central feature of AODTI. All DHHS front-line employees were trained in the tools needed to screen, assess, and make effective referrals to A&D agencies. For example, the level II training curriculum certifies staff in the administration and interpretation of the Substance Abuse Subtle Screening Inventory. Workers learn how to differentiate between clients who are substance users, abusers, or potentially dependent on alcohol or drugs. The curriculum also includes indepth training on the A&D treatment levels of intensity (i.e., residential, day, intensive outpatient, and outpatient treatment; and self-help programs). The 3,000 assessments completed on CPS cases in 1996-97 represent the fullest extent of implementation of this initial policy, and approximately 60 percent of clients assessed (mothers and fathers) were found to be involved with alcohol and/or drugs.

After the CPS assessment policy suspension (August 1997), the A&D Services Division improved its standardized assessment and data collection system with its contracted community treatment providers. The division centralized its treatment authorization and information system to monitor provider capacity to better manage the available treatment slots in the county, ensure that clients who needed intensive treatment were appropriately referred, and ensure that clients needing less intensive intervention were effectively matched with appropriate providers. The new system also ensured the widest possible access to clients from all potential referral sources, including child welfare, welfare, criminal justice, public health, and mental health, as well as self-referral. Knowing as much as possible about the severity of the needs of clients entering the treatment system was considered a means of improving their retention in treatment and the likelihood of successful outcomes.

> *The Importance of Assessment: Knowing as much as possible about the severity of client needs helped improve client*

The A&D Services Division also responded to the CPS division's belief that worker caseload fluctuations required CPS to screen, initially assess, and refer clients for A&D services. The A&D Services Division developed and piloted a new A&D referral form, preliminary assessment instrument, and treatment matching protocols, resulting in two options for CPS and other county agencies to secure A&D Services Division services for their clients:

1. Workers could complete a brief referral form and make an appointment with an A&D Services Division worker for a preliminary assessment of treatment need, authorization for treatment, and referral to an A&D Services Division-funded treatment agency (see appendix VI-A for the referral form); or
2. Workers who had completed level II training could complete the preliminary assessment and obtain authorization over the telephone for their client to go directly to the A&D Services Division-funded treatment agency (see appendix VI-B for the preliminary assessment and treatment authorization forms).

The advantage to CPS and other county line staff of completing the preliminary assessment is that their client avoids the two-step process for treatment authorization from the A&D Services Division. Instead, the A&D Services Division staff discuss the preliminary assessment results with the person who conducted the assessment, supply information about which community provider has immediate capacity for treatment entry, and help the staff person obtain a treatment resource in a timely manner. The new screening, assessment, and treatment authorization policy was adopted by the CPS division in January 1999.

The new protocol considerably expanded the treatment demand and utilization information available to the A&D Services Division, which improved its ability to allocate resources based on data and the principles guiding the division's SOC approach. For clients, focusing on the importance of assessment significantly improves their chances of being connected with appropriate services, which improves long-term outcomes. For the system, the change reduces the inefficient use of scarce resources that results from referring clients to inappropriate treatment programs.

Among CPS clients who were assessed for A&D problems, 81 percent were involved with alcohol and/or drugs. Of those, 45 percent were assessed as chemically dependent, 21 percent as substance abusers, and 15 percent as substance users.

Appropriate treatment referrals were also enhanced by the new procedures. Twenty-six percent of the referrals were for intensive detoxification and residential services, and 22 percent were for outpatient services. This appears to be an appropriate mix of service referrals, given clients' assessed severity, and helps reduce the automatic referral to long waiting lists for more intensive service that existed before AODTI. As a result, clients are assessed, their assessed level of need is determined, and they are referred to services that are appropriate to their level of need. In addition, the SOC treatment coordinators monitor treatment availability and report that waiting lists have diminished and clients are gaining quicker entry into services.

Service Access Expanded: Clients are receiving referrals to more appropriate levels of care under the new SOC screening and assessment process.

In summary, with the shift in division leadership, implementation of a values- and data-driven decision making approach, establishment of the SOC assessment process, and reinstitution of the CPS assessment policy, the A&D Services Division has become a much more active partner in the treatment process. AODTI is meeting its original goals of serving clients from diverse agencies and providing differentiated services. As a result, the A&D Services Division has shifted from serving as a funding agent to becoming a more effective leader in using the community's treatment resources and, thus, ensuring that county priorities for service delivery are met.

The review of assessment policies and practices established screening and assessment as distinct activities with specialized functions. In the initial phase of AODTI, it was assumed that CPS workers could be trained to *both* screen and assess substance abuse problems. Some of the CPS workers do, in fact, perform both functions, but others, as a result of their training, do a better job at referring clients for assessment.

"Better Handoffs": When CPS workers are more familiar with screening procedures, they make better and more appropriate referrals to treatment

Daily Practice—Client Engagement and Retention in Care

The justification for matching treatment to appropriate levels of care is that it fosters client engagement and retention, and therefore increases the likelihood of recovery. Six years ago, prior to the launch of AODTI, CPS referred most of its clients to residential treatment or Alcoholics Anonymous and Narcotics Anonymous. At the time, these were the only treatments that workers recognized or understood, despite the availability of such options as day treatment and intensive outpatient services. Often, clients remained on waiting lists for up to 9 weeks or re-entered the county systems until they lost their children or were incarcerated.

Now, the SOC approach provides three tiers of service referrals:

1. The most intensive tier—referral to community-based residential and detoxification facilities— made up 26 percent (n=1,392) of referrals in the year after SOC implementation;
2. Referrals for outpatient, intensive outpatient, and day treatment made up 22 percent (n=1,189) of referrals; and
3. The least intensive but largest category of community resources—referral to community-based self-help groups—made up 21 percent (n=1,107) of referrals.

Methadone programs and Options For Recovery (see below), which cut across service levels and intensity, are not included in these tiers.

The A&D and CPS divisions have implemented additional programs, including the Options For Recovery program, which provides support and treatment services to women with children entering the child welfare system, to increase the likelihood that the mothers will maintain child custody or move quickly toward reunification if the family is separated. Upon a mother's entry into child welfare, an A&D Services Division-funded case manager expedites the linkages between child welfare and substance abuse treatment agencies and assists CPS social workers in assessing the mother with a substance-exposed infant. Within 30 days of the woman's entry into treatment, a multidisciplinary team is assembled that includes the client, who plays a significant role in case planning and implementation, as well as all of the players in the family's life, so that the case plan can reduce conflict among systems and raise the potential for client success. Option's case managers are outstationed at the provider sites to improve integration and ease access for clients.

The second program, the Early Intervention Specialists Project, targets CPS cases assessed as at high risk for child abuse/neglect and with substance abuse problems. Clients include pregnant women, women with substance-exposed infants, and families with children under the age of 3 years. The project provides outreach, intervention, and preliminary assessment of substance abuse problems at the time of the CPS detention hearing (no more than 72 hours after a child is placed in protective custody). Early intervention specialists with experience in both the CPS and A&D systems are stationed at the dependency court and conduct outreach and interventions with parents. They also educate clients about the treatment process and the court's expectations for reunification with their children. While this program is relatively new and evaluation data are not yet available, the specialists report that clients who are approached in a reasonable and supportive manner are likely to admit to drug use, acknowledge that substance abuse is affecting their lives, and cooperate with treatment. The early intervention staff can authorize treatment, which allows them to obtain services quickly.

Early intervention specialists with experience in CPS and A&D are outstationed at the dependency court.

More recently, the A&D Services Division has used tobacco litigation settlement monies to fund the Recovery Specialist Project. Modeled on the Options For Recovery and Early Intervention Specialists Project, the Recovery Specialist Project engages and retains CPS clients in substance abuse treatment. Recovery specialists provide support to parents and serve as a liaison to CPS and community-based provider partners. The specialists were also scheduled to work with a new dependency drug court that was implemented in the fall of 2001.

In each of these programs, treatment is intended to be holistic, focusing on the family and its diverse needs. The client and family play primary roles in case planning and implementation. Workers have treatment knowledge and skills and understand the workings of the other systems so as to support their clients and advocate for them effectively.

Daily Practice—Services to Children

AODTI recognizes that A&D problems are intergenerational and can have a significant impact on children. The A&D Services Division offers secondary drug prevention programs in the schools, intensive mental health services for the severely disturbed, and therapy groups for youths with A&D problems. The latter, developed in part through AODTI's treatment expansion component, take place in schools and community centers, and participants receive drug education, prepare for drug treatment, and obtain emotional support. The groups are facilitated by counselors from the A&D Services Division, public health nurses, social workers, and other community workers. Finally, California's Temporary Assistance for Needy Families (TANF) and child welfare services have made ancillary programs available, such as childcare and parenting classes, to children of substance abusers in treatment.

Staff acknowledge a gap in A&D services for youth, especially for children with mild and moderate mental health impairments, such as attention deficit hyperactivity disorder, mood disorders, learning disabilities, and deficits in social skills. These gaps have come to the attention of the A&D Services Division and the county children's mental health services, which have been developing intensive services for eligible youth who do not quality for the State's Medicaid program. The State has recently allocated funding for youth treatment services, which are expected to support a youth system of care comparable to the county's adult system, and this would fill some of the most significant gaps in service.

Their collaboration has allowed the A&D Services Division and the children's mental health services to specify a need for training in area referral sources to strengthen the substance abuse identification skills and capacity of their staffs to engage youth and move them toward assessment and treatment. The two departments have also recommended that service providers develop a "best practices" model to provide youth in their programs with coordinated mental health and substance abuse services. Training and technical assistance will help each department understand the requirements of the other, and help their programs maximize funding streams to expand service capacity.

Joint Accountability and Shared Outcomes

The Sacramento SOC approach represents one of the greatest advances in outcomes accountability of a county-level project in the Nation, as it has good assessment data at admission and discharge, as well as plans for postdischarge follow-up. In addition, Sacramento's A&D Services Division has participated actively in State discussions of implementing the CSAT outcomes project. The county is using the CSAT system to enhance its monitoring of treatment providers.

Information Sharing and Data Systems

Parents assessed for A&D problems through the division's SOC complete a release of information for the exchange of information regarding their treatment records with agencies named in the consent agreement.

Although California's statewide data system for substance abuse treatment agencies does not include information about clients' children, Sacramento added this in 1998 as a requirement for providers in its SOC approach. The Sacramento supplement to the California Alcohol and Drug Data Set (see Appendix VI-C) collects data from clients on the use of the county's health, social service, and criminal justice systems, in addition to child-related services. The A&D Services Division developed a Microsoft Access-based information system to manage the data collected through the supplement.

The CADDS Supplement: Additional data collected at admission and discharge include the core items tested by CSAT in its outcome monitoring effort.

In early 2000, the A&D Services Division revised its dataset supplement to include information on clients' substance use during the 30 days prior to treatment and at discharge, added categories on the psychosocial status of the client, and added questions about the use of county services in the past 30 days and past 6 months. The supplement includes the cross-State core data items currently being tested through CSAT's outcome monitoring program, which are collected from all county-funded programs. In addition to the items required by the Federal minimum dataset, the supplement items collected at admission and discharge include:

In the past 30 days, and 6 months...

- How many days have you stayed overnight in a hospital for medical problems?
- How many days have you stayed overnight in a hospital for psychiatric problems?
- How many days have you participated in self-help services?
- How many times have you visited an emergency room?
- How many times have you been to an emergency psychiatric facility?
- How many times have you been arrested?
- How many days have you spent in jail or prison?
- How many days have you spent in involuntary detox?
- How many days have you been homeless?
- How many days have you lived with someone with an AOD problem?
- How many days did you have serious conflicts with your family?
- How many days did you have serious conflicts with other people?

New questions on the client's family and support system:

- How many people who are not AOD abusers can you turn to when in need of help?
- How many children do you have, aged 17 or less (birth or adopted), whether they live in your home or not?
- How many children aged 17 or less are living in your household?
- How many of your children are living with someone else because of a child protection court order?
- For how many of your children living with someone else have you had your parental rights terminated?

Whether the client was involved with any of these systems...

- Criminal justice,
- Child welfare/CPS,
- Home visitation,
- Public health,
- Mental health,
- Adult services/in home supportive services,
- Housing assistance,
- California' TANF program,
- Vocational/educational,
- General assistance,

- Supplemental Security Income/Supplemental Disability Income, and
- Case management.

Training and Staff Development

AODTI was never solely a training initiative, although training was its initial focus. Staff attend four weekly daylong sessions for each training level. The curriculum, training manuals, and materials developed by Sacramento County include:

- Level I: Basic A&D information, identification skills and terminology— required training for all DHHS employees;
- Level II: Screening, preliminary assessment, and intervention skills—required training for all DHHS staff with clinical/case management roles; and
- Level III: Group intervention skills—required training for all A&D Services Division counselors and voluntary training for all other DHHS staff and community agencies.

The CPS staff trained by AODTI are clearly doing better at identifying clients in need of A&D assessment. Thus, the training has benefitted both the child welfare and treatment systems clients.

Budgeting and Program Sustainability

The Annie E. Casey Foundation provided the initial funding for the AODTI training program and much of the evaluation component, and other, in-kind resources were provided by the county's DHHS. The A&D Services Division's ongoing training efforts are supported, in part, by revenue from marketing AODTI to two other California counties and the State of Oklahoma Department of Human Services. Except for some of its evaluation activities, AODTI is no longer dependent on foundation support. As a result of continuing in-kind support from the A&D Services Division and DHHS, AODTI has become integrated into ongoing county operations.

Working with the Courts

Early on, the county's criminal justice cabinet voted to support extending the AODTI training into the justice system for the county's probation, court, and legal staff. Even with unanimous support from the cabinet, implementation was difficult, as each Services Division had different training needs and availability. The A&D Services Division succeeded in accommodating the needs of each division. For example, lawyers participated in a "Lawyers for Lunch" training series that offered a condensed version of the six most critical topics. Home court judges completed a daylong training session and received the level I training manuals for reference. These collaborative efforts paid significant dividends over time. The county's jail medical systems, sheriff's office, and probation department worked with the A&D Services Division to develop a women's jail treatment program, which reaches out to pregnant and parenting offenders in jail, provides group treatment services, and transitions the women to outside residential and outpatient services upon release. The sheriff's department, Division of Mental Health, and A&D Services Division successfully used a mentally ill offender crime reduction grant to provide case management to incarcerated, dually diagnosed offenders, and place them in wraparound services upon release to help reduce recidivism.

At the time of the site visit, a dependency drug court was in the planning stages as a collaborative effort by several county systems and community partners. A&D counselors are currently outstationed in the existing drug court and new funding from the tobacco litigation settlement will make it possible to place case managers in dependency courts to ensure that interventions with CPS-involved families occur immediately, increasing the chance of successful reunification.

Working with Related Agencies and the Community

The division's commitment to collaboration and the SOC's flexibility have ensured referrals from diverse agencies and partners, including CPS, welfare, public health, mental health, and the justice system. An especially close link has been formed with the juvenile justice system, and this was solidified by a demonstration program that tracks and provides services to the many children who "graduate" from the child welfare system to the juvenile justice system.

Sheriff's officers trained by AODTI now use their new skills to make decisions about home incarceration/electronic monitoring, as well as more effective referrals to the SOC. Probation officers are partners in some of the youth group interventions provided by A&D counselors and are collaborating with the A&D mental health divisions on the new youth treatment planning effort.

Summary

The Sacramento innovations represent one of the broadest uses of several elements of the 10-part framework in the sites visited. Indeed, the A&D Services Division administrator has helped refine the framework, including the collaborative capacity instrument. Sacramento's training effort has been linked to accountability reforms and a better information and evaluation system than any of the other sites examined.

References

1. This case study relies upon data from the AODTI evaluation undertaken by Children and Family Futures with the support of the Annie E. Casey Foundation and assistance from the staff of the Sacramento County A&D Services Division.

VII. CUYAHOGA COUNTY'S SOBRIETY TREATMENT AND RECOVERY TEAMS

Background and Project Description

The Sobriety Treatment and Recovery Teams (START) program was initiated in March 1997 under the leadership of Judith Goodhand, Executive Director of the Cuyahoga County Department of Children and Family Services,[1] who had operated a similar program in Toledo, Ohio. With funding from the Annie E. Casey Foundation for a linked set of child welfare reform projects, START focuses on families in which a pregnant mother is using drugs or a baby tests positive for drugs at birth. Two START units, staffed by teams of 10 social workers and 10 family advocates (women in recovery), were established in the child welfare agency.

The Federal Adoption and Safe Families Act (ASFA), through Ohio legislation HB 484, enables the department to take permanent custody if a parent has failed two episodes of substance abuse treatment. Ohio's language goes well beyond the ASFA requirements and represents one of the most stringent interpretations in the Nation of a State's obligation to remove children in cases of substance abuse. The Ohio legislation has increased the perceived need for the START program, and also led to expanding treatment capacity using Temporary Assistance for Needy Families (TANF) and State funds based on an estimate of this population's future needs. The State and counties have devoted significant effort to operationally defining "two treatment failures," including establishment of a Cuyahoga County 484 working group to define treatment failure and develop a policy response to the State legislation. The question of whether relapse is a "treatment failure" has led to extensive discussions among substance abuse treatment providers and Department of Children and Family Services (DCFS) staff regarding the stigma of addiction and concerns about child safety.

Underlying Values and Principles

The START program is based on 12 tenets that were discussed at great length by the program developers, service providers, and staff. The orientation to abstinence is very strong—the first principle begins, "We believe that addiction is a disease that requires abstinence." Service providers are expected to submit information about a client's relapse the day it is discovered, so that the social worker can respond immediately with a home visit or other intervention.

START also relies heavily on family advocates who work directly with clients and provide a wealth of knowledge in addiction and recovery to the child welfare staff. The advocates have typically been in recovery for at least 3 years and are participating in a 12-step program. Program supporters acknowledge that the advocates regard the clients differently than the social workers, and can sometimes identify signs of continuing use and abuse that traditional staff may not recognize. The demands on the advocates are heavy due to the emotional drain of involvement with a troubled family's crises on a day-to-day basis, and 6 of the original 10 advocates have left the program.

Efforts have been made to match social workers and advocates, since the working relationship is very close. As one worker put it, "Really extraordinary people were hired for this unit—maybe that's why they work well together." Most of the START social workers had requested the assignments and knew more about chemical dependency issues than their peers.

Daily Practice—Client Intake, Screening, and Assessment

During the initial negotiations that led to START, planners agreed that cases would be assigned to START by a hospital when a patient had a positive toxicological screen prenatally or at birth, because prenatal exposure was seen as a major problem in Cuyahoga County. When cases are assigned to the START team,

1. Within 24 hours of the referral, the case is referred by the DCFS intake division to START.
2. Within 72 hours, the intake worker schedules a staffing meeting for safety planning with the family.
3. The mother is referred to and begins treatment within 24 hours of the staffing/team meeting.
4. START workers accompany the mother to the drug assessment within 72 hours of the child's birth. Appropriate releases are obtained for ongoing monitoring of the client's treatment progress by START and the provider at this appointment.

The intake unit maintains its role of abuse and neglect investigation, while the START workers initiate drug treatment services to the family.

The goal is to ensure that a first treatment contact occurs within 48-72 hours of the call to the START team. As of August 2,000, 27 percent of START clients had received a drug assessment, pretreatment contact, or treatment contact within 72 hours of notification of START. An additional 25 percent had contact with a substance abuse treatment agency (for treatment) within the first week and 33 percent within the first 30 days. Thus, 87 percent of START clients received some kind of treatment contact within the first month after the hospital notified the START team.

Each START team is responsible for only 15 cases; in the program's first 2 years, 299 families were referred to START out of nearly 35,000 possible cases.

The 10 START teams have a total capacity of 150 clients (each team is responsible for 15 cases). The hotline receives approximately 30 positive toxicology referrals a month, but START can accept only 5 or 6 of these new cases. A total of 17,600 cases were referred for DCFS intake in 1998; these include some multiple referral cases. Many parents beyond mothers who have just given birth could benefit from START, and county staff are debating how to respond to the increased need for treatment and client support that has resulted from ASFA.

At the time of the site visit, START could not increase its capacity because its low staff-to-client ratio is critical to the program. The cases require very intense work due to the many family members who must be served as part of the family-focused approach; the START staff must conduct very extensive case management and liaison work to ensure treatment access, entry, and compliance; and the frequency of contact with families adds to the complexity of cases. In START's first 2 years, 253 families were referred to it. Of this group, 165 families had children taken into custody; 34 families achieved reunification, 100 families maintained custody in their own homes, and the remainder are receiving family reunification services.

Although cocaine addiction was the major impetus for the program, 30 percent of clients in the first 2 years had other drugs of choice, primarily marijuana. This may be due to the fact that marijuana remains in the system longer than other drugs. Since a positive toxicology screen is the trigger for START involvement, more cases of marijuana use may be identified than of drugs that are more difficult to detect. Moreover, client interview indicate that some who tested positive for marijuana actually use many drugs. DCFS staff believe that mothers with marijuana problems are more likely to retain custody than those with cocaine or heroin addiction.

Five years ago, the county drug and alcohol board used Center for Substance Abuse Treatment (CSAT) funding to develop assessment tools that would refine tracking of treatment outcomes, with the assistance of experts at the University of Akron. The assessment requires approximately 90 to 120 minutes and was originally designed as a research tool. The tool is now computerized and can be administered by all START counselors in their own offices.

Daily Practice—Client Engagement and Retention in Care

The family advocates are at the heart of client engagement in their efforts to conduct outreach and provide support to enter substance abuse treatment. The cap of 15 cases per team enables close client contact. The teams see the family at least once a week at first, when they accompany the clients to their first three treatment and/or meeting sessions.

Close links between service providers and the START team are key to the program, with monthly meetings of providers and supervisors and weekly contact between the team and service provider while the client is in treatment. Communication protocols include release and protection of confidential information, which has improved relationships between agencies. Providers previously would not disclose

> *Confidentiality issues have raised questions of underlying values; progress reports are shared with DCFS, but workers describe decisions about what to disclose as "a tightrope we walk all the time."*

relapse out of the fear that clients' children would be taken away. Treatment providers and DCFS staff had a lengthy discussion about the definitions of "relapse" and "slips," but both sides made adjustments; DCFS staff became more flexible in their responses to relapses, and substance abuse treatment counselors became more willing to report relapse as a result. Generally, providers working with START clients have been willing to provide ongoing information to DCFS on treatment progress without raising confidentiality issues, since only progress reports, submitted on a standard form, are shared with DCFS. Treatment providers believe that having the workers accompany the clients to their first few appointments with the treatment agency is what makes the difference. This is in marked contrast to typical DCFS procedures, in which referrals are made simply by faxing a form to the treatment agencies.

The county's substance abuse treatment capacity has expanded over the past few years and, as a result, START clients have no waiting lists because they receive priority for substance abuse treatment. Any parent needing a residential program can choose from more than one, although not all of these programs can accommodate children. A mother with a single child can usually enroll in a residential program; however, admissions for multiple-sibling families are still limited.

Daily Practice—Services to Children

The agency assigns responsibility to a specific staff member for services coordination with childcare, health, employment training, and other agencies. Links to developmental disabilities and Head Start programs are considered especially important. Many children of clients are eligible for early intervention programs as a result of both their substance exposure and attachment issues. Some substance abuse treatment providers work with children on recurring issues such as fine-motor skills, while others emphasize services to children. One staff member noted, "Children are the real indicators of how mom is doing and they are part of the overall healing."

In one newly developed program, therapeutic classrooms are available for children from age 9 months to 5 years. A child intervention specialist works with these children, and capacity is 17 preschoolers and 10 infants and toddlers. This program has encouraged mothers to bring their children to therapy, and workers believe that the program has had a positive client engagement impact on the mothers as well as the children.

Joint Accountability and Shared Outcomes

State legislation, informally known as the "two-strikes law," may require new training, since it represents a major policy shift in child welfare-treatement linkages.

Data are continuously collected by an evaluation team from the School of Social Work at the University of North Carolina and the Research Triangle Institute, with funding from the Annie E. Casey Foundation as part of its Family to Family foster care program.

In its August 2000 report on START, the evaluation team presented its initial findings, and was impressed by START's client engagement activities during its first 2 years. Of the 253 clients in the START program, 81 percent received some kind of substance abuse treatment, in contrast with only 45 percent of a comparison group of mothers with positive toxicology reports who were not enrolled in the START program. In addition, two-thirds of the women discharged from a first substance abuse treatment program entered a second or third program, which is a positive result because

> The consistent ongoing contact of the START teams, the treatment providers, and the START mothers assured that mothers who were less than successful in the first program were at least offered the chance to begin a second or third program as needed.

The START evaluation team collected data on child welfare outcomes, particularly the filing of subsequent reports of child abuse or neglect among children of START mothers. At baseline, the children (those testing positive at birth) of 53 percent of the START mothers were placed in out-of-home care. Follow-up data have proven difficult to collect, but the 2-year evaluation concluded that START infants were not significantly more likely to be removed than a comparison group. However, as many evaluations that used placement rates as a dependent variable have noted, a child may be more likely to be removed when the family is observed more frequently. In addition, short-term placements may produce benefits that are only clear over the long term.

Information Sharing and Data Systems

As part of its Family to Family program, the Annie E. Casey Foundation has provided Cuyahoga County with significant funding to upgrade its child welfare information systems. The County has developed a family and children tracking system to help support the evaluation of START. County staff hope to hire an internal systems analyst to help them conduct their own analysis of their child welfare data. Information exchange procedures have been developed with providers and START.

Training and Staff Development

START staff are trained in all aspects of chemical dependency use and team-building. The Annie E. Casey Foundation has provided START with training and technical assistance resources through its Family to Family program. Training resources include information on:

- Drug treatment basics;
- Case-focused consultation on drug-related issues;
- Risk assessment, case planning, time management, conflict management, family preservation, and work liability for social workers;
- Overview of child welfare practice and professionalism in practice for family advocates;
- Case management and decision making;
- Eliciting and identifying strengths;
- Methods for helping abusers and those they abuse;
- Team building;
- Relapse prevention, boundaries, and family support;
- Cultural diversity;
- Drug paraphernalia;
- Worker safety; and
- Motivational interviewing.

Additional training will be provided to respond to the new State HR 484 “two strikes” legislation.

Budgeting and Program Sustainability

START is supported by State and county funds, as well as grants from the Annie E. Casey Foundation for evaluation and special training. The State legislature has also appropriated $1.2 million in line item funding for START and has tracked its progress closely.

An attempt is underway to add four more units to START. Expanding the project has been a major focus of START managers for the past year, and they believe that if the program had greater visibility in more geographic areas and more supervisors, it might spread more than it has. The evaluation also suggested that non-START CPS workers saw the START teams as having a relatively easy role, which raises the question of how to replicate the low caseloads and secure buy-in from workers with larger caseloads. This is in part a budget issue, but seems also to involve personnel and training issues, given the different roles of the START team members and their counterparts.

Working with the Courts

START staff acknowledge that the courts' response to their efforts depends largely on the judge, and that no uniform policy has been established. They believe that the relationship with the courts can improve over time with additional training. The courts were not significantly involved in the original design of START, but were subsequently consulted about its operations and expansion.

Working with Related Agencies and the Community

Treatment providers try to assess for mental health problems that are co-occurring with substance abuse problems. Limited section 8 housing vouchers have been made available to all clients who have made progress in treatment and for whom housing is the last barrier to reunification, but the vouchers are not available to all clients.

Summary

Critical innovations in Cuyahoga County are the use of addiction specialists, rapid response to the prenatal substance abuse that triggers START involvement, ongoing training and evaluation, and staffing for services provided by external agencies to children and parents. START is undoubtedly a national client engagement model.

The attempt to expand the program's capacity is taking place in the new climate created by the "two-strikes" law, which will challenge the child welfare-substance abuse treatment alliance, and will require even greater clarity about the shared missions of the two agencies.

Reference

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1. This case study has benefitted from the extensive documentation of the START model by HomeSafe and support by the Annie E. Casey Foundation. The report *START: A Child Welfare Model for Drug-Affected Families* is available at the foundation's Web site, at www.aecf.org.

VIII. JACKSONVILLE'S
TREATMENT AGENCY INITIATED PROGRAM

Background and Project Description

The Jacksonville, Florida, site was implemented in spring 2000 and is thus the newest of all the sites studied for this report. In part, this assessment describes the efforts of a newly implemented program to plan and develop strategies to address substance abuse in child welfare cases. The project's key feature is its use of Temporary Assistance for Needy Families (TANF) funds (under the Florida WAGES program) to outstation alcohol and drug (A&D) counselors in specific child protective services (CPS) investigation units. These counselors assist child welfare services (CWS) workers in assessment, treatment referral, and engagement of parents in the substance abuse programs.

Jacksonville is the major population center of region IV of the Florida Department of Children and Families. Jacksonville is one of four sites of the Edna McConnell Clark Foundation's Community Partnerships, which are child welfare reforms aimed at increasing community involvement in the prevention mission of CPS, including setting up a "two-track" system in which less serious cases of abuse and neglect are handled by community agencies. All four foundation-funded sites include a family-focused treatment plan, the individualized course of action (ICA), which incorporates the family's strengths and the input of all the relevant agencies and staff. As a result of its participating in Community Partnerships, Jacksonville has had training and technical assistance resources available.

Jacksonville has also benefitted from the involvement of the Child Welfare League of America (CWLA), which provided technical assistance, including a "think tank" training session in February 2000. Philip Diaz, Director of Gateway Community Services, the largest community treatment agency in northeast Florida, was a consultant on substance abuse issues for the CWLA. The think tank resulted in the creation of a task force on substance abuse and child welfare that has taken the lead in the implementation of the outstationed workers initiative.

Gateway has been a very active player in the community partnership under both its prior director, Virginia Borrok, and Philip Diaz. The original community governance unit for the community partnership did not include A&D representatives, but Gateway successfully sought membership, and its staff became active participants.

Underlying Values and Principles

For several years, the senior child welfare staff expressed a view that substance abuse treatment was not effective with the CPS population and frustration at the fact that families re-enter the substance abuse treatment system too often which had previously hampered cooperation between child welfare and substance abuse staff. Gradually, through efforts by Gateway and State officials, this attitude has changed, and joint efforts have become possible. A steering committee of the community partnership that included officials from both child welfare services and Gateway has held regular quarterly meetings. Senior child welfare officials now see the potential for a seamless system that provides substance abuse treatment on demand for all TANF and CWS clients who need it, and have provided leadership in moving toward such a system.

Daily Practice—Client Intake, Screening, and Assessment

The Jacksonville region is using part of its TANF allocation to fund substance abuse assessments for parents reported to CPS. Staff in both systems have welcomed the assignment of Gateway substance abuse counselors to child safety teams and the decision to house them in the Jacksonville CWS office. Substance abuse treatment system workers believe that this provides CWS clients with a smooth entry into the system, since they are not required to make appointments at a separate agency for an assessment. As of mid-2000, six units with a Gateway staff member were performing this function.

CWS workers cite the ICA process as making "a huge difference," by providing a tool for bringing all of the agencies and resources together with the family. Having substance abuse workers on the team has been the major breakthrough for A&D services (ADS)-CWS relations. As one supervisor noted, "Having substance abuse staff as part of the ICA team makes all the difference in getting this problem discussed."

Treatment Agency Staff Out-stationing: The staff of Gateway operate out of the CWS offices and this has been welcomed by the entire CWS unit.

The Gateway substance abuse assessment takes approximately 2 hours and results in an initial *Diagnostic and Statistical Manual of Mental Disorders* diagnosis using the Addiction Severity Index as an interview/assessment tool, followed by a more detailed psychosocial assessment based on the American Society of Addiction Medicine's patient placement criteria for treatment referrals. CWS ranks the cases to be assessed by Gateway according to severity: needs immediate response, 3-hour response, 24-hour response, or 72-hour response. Because of this, Gateway staff describe the CPS investigations unit as somewhat more responsive to substance abuse treatment staff than the units concerned with longer term services. The CWS investigators have found that the A&D assessment resources help meet the mission of the investigations unit, to make determinations regarding allegations of child abuse and/or neglect and the level of risk to the child, and to move the case to closure or ongoing services.

One supervisor described the close working relationships between CWS front-line workers and the Gateway substance abuse treatment staff as follows: "CWS workers have five new cases every day, and three of them have alcohol and/or drug problems. Having Gateway to help with those cases is a big help and keeps cases from falling through the cracks." Substance abuse treatment staff are becoming more knowledgeable about the child welfare system, and CWS staff are receiving more input in addressing A&D abuse in their case plans.

Daily Practice—Client Engagement and Retention in Care

One of the most important efforts of the outstationed substance abuse treatment staff members is more rapid engagement in the treatment process through the joint approach between Gateway staff and the CWS units to which they are assigned. CWS workers in each unit refer to and consult with the Gateway staff member regarding the families assigned to the unit. Drug testing by the Gateway staff is an integral part of the assessment and treatment monitoring process, and is continued by CWS after treatment concludes. Relapse is monitored by the Gateway staff as part of its early recovery services. The Gateway and CWS staff meet regularly to discuss client progress.

Daily Practice—Services to Children

The Jacksonville program has devoted significant resources to services for children. In addition to providing childcare while parents are in treatment, private practitioners operate groups for children of substance abusers (COSAs) in one of the family centers in Jacksonville. Gateway has also provided substance abuse prevention and group services to youth in the foster care system. Child guidance staff have provided counseling services to youth in the substance abuse treatment centers who appear to be at high risk as a result of their parents' A&D abuse. Gateway also participates in a network of residential programs that address the needs of children and their parents.

Other Florida programs, including The Village South located in Miami, have established mechanisms for permitting a drug treatment agency to serve as a foster placement, so that children can remain with their mothers in the program. The children are placed in protective custody under the supervision of the substance abuse treatment agency staff, who are responsible for the child's immediate safety. Gateway and CWS officials have explored similar arrangements.

Joint Accountability and Shared Outcomes

At the time of the Jacksonville site visit, staff had identified joint accountability and shared outcomes as an arena for future action. The CWS and Gateway agencies had reached substantial agreement on outcomes that should be measured pertaining to more rapid entry into treatment and treatment completion.

Information Sharing and Data Systems

Although the Jacksonville project participates in State child welfare and substance abuse information systems, no formal evaluation process has been established to date. The partnership steering committee has adopted targets for increasing the number of referrals for treatment, assessments completed, and treatment completions, but no data are available on the extent to which these goals have been achieved. An effort is underway to assess the dropoff points at which clients who are referred do not show up for assessments or treatment. The task force has negotiated client consent forms for substance abuse treatment agencies to exchange client information with CWS and is working with the Legal Action Center to conduct training on confidentiality issues.

Training and Staff Development

Jacksonville staff believe that training is key to changing systems, and training was identified as the highest priority need by think tank conference participants. In the past, training for CWS and substance abuse front-line workers has been inadequate due to limited resources. One staff member explained the dilemma produced by limited resources: "The resource choice in the past has been to treat someone or train someone—so you treat." More recently, a 3-day training program by HomeSafe (a Washington State-based organization that also provided Cuyahoga County's START training with support from the Annie E. Casey Foundation) for equal numbers of A&D and CWS staff was welcomed by both agencies. This training emphasized motivational counseling techniques and staff responded favorably. "Co-location and crosstraining are what make it work," said one supervisor. Gateway and the CWLA have offered additional crosstraining.

Budgeting and Program Sustainability

Redefinition of TANF Eligibility Has Assisted CWS Families: In Florida, State definitions of "needy families" for TANF include CWS parents who have lost custody of their children, which has increased the funding available to the Jacksonville programs.

Funding for treatment services is provided by the State agency responsible for A&D treatment through the substance abuse prevention and treatment block grant. In addition to using TANF funds for the outstationed counselors, Florida has tapped TANF for treatment services, as well as Medicaid funds for some eligible services. A flexible interpretation of TANF eligibility for parents who are in the system or potentially on welfare has helped target funding to more parents than could be served previously. Specifically, the State of Florida defines "needy families" according to income level instead of whether they receive cash assistance through TANF. As a result, TANF allocations for support services can be used to meet the needs of low-income families, including those who have lost custody of their children through the department of children and families. City of Jacksonville funding has been used for detoxification services and supportive housing, and the Children's Commission of Jacksonville has provided support for childcare services.

Working with the Courts

According to staff, some parents' attorneys urge their clients not to comply with the case investigation and early treatment planning process, and some clients have not kept appointments on their attorneys' advice. Attorneys sometimes advise parents not to comply with treatment requirements unless and until the court has ordered them to do so, based on the belief that seeking A&D treatment prior to the conclusion of the investigation or a court order for such treatment could be interpreted by the court and/or CWS as a negative condition during the investigation phase of the CWS case. Senior CWS staff hope that by offering training to judges from the region, the judges will not misinterpret the need for A&D services during the investigation phase of the case.

Working with Other Agencies and the Community

Jacksonville policy and community leaders are convinced that the connections between child abuse, substance abuse, domestic violence, and mental health must be addressed jointly. The ICA represents an integrated plan across all of these agencies in response to clients' needs for more than one set of services. Additionally, a video that reflects the needed connections among these services has been developed for training and public education.

The Community Partnership for the Protection of Children has enabled community members from five target areas to participate in the governance of the partnership. This connection to community members has helped the task force address substance abuse issues through culturally appropriate interventions and services. Community members have also volunteered to provide safe homes for respite care for children while their parents participate in substance abuse treatment services.

Staff repeatedly refer to the close connections between domestic violence and A&D abuse, and believe that they address these issues jointly. The task force has created a network of all the halfway houses in town to address the major need for transitional housing for women and children. As in many other sites around the country, the collaboration hopes to improve geographic access, transportation, and childcare in the near future.

Summary

As Jacksonville moves from planning to operations, its innovations include the use of the ICA process to create a single family plan. Another major asset in Jacksonville's program has been an active substance abuse treatment agency that has sought equal status with CWS agencies and has been willing to outstation its staff in CWS offices.

IX. SAN DIEGO COUNTY'S DEPENDENCY COURT RECOVERY PROJECT

Background and Project Description

The San Diego County Dependency Court Recovery Project (DCRP) started in 1998 at the suggestion of Judge James Milliken, Presiding Judge of Juvenile Court, which hears both juvenile delinquency and children's dependency cases. Judge Milliken observed that San Diego County has 3,000 new dependency cases annually, resulting from 90,000 reports of suspected maltreatment, with 7,000 children under county jurisdiction and about 4,500 in foster placement. He also discovered that family reunification was taking too long, an average of 34 months from intake to permanent placement, twice the limit under California law and almost three times the limit imposed by the Adoption and Safe Families Act (ASFA). "We didn't feel like we were reunifying enough families," said Judge Milliken. He developed an agreement with Dr. Robert Ross, then-Director of Health and Human Services, to establish joint policies on alcohol and drug and child welfare issues. Together, they organized the DCRP policy group, which continues to set policy and direction for the project.

The goal of the DCRP is to achieve a reunification or permanency plan on time—in essence, to adhere to California's ASFA law, which calls for permanent placements within 6 months for children under age 3 years, and within 12 months for older children. According to Judge Milliken, 80 percent of San Diego County's cases have a predominant drug or alcohol issue. While other issues, such as sexual and physical abuse, domestic violence, and mental health may be involved, drugs and alcohol are usually the triggers of the problem. Treatment is seen as a prerequisite to working on other issues.

The alcohol and drug treatment programs in the county had long waiting lists. At clients' 6-month reviews, almost no parents had received substance abuse treatment because the division of children's services (DCS) had no control over available treatment slots. Addicted parents and social workers with no authority had to try to arrange for substance abuse treatment, and the county could not ensure that treatment was available.

With the board of supervisors' approval, a new approach was designed, giving parents in the dependency system top priority for substance abuse treatment. The DCRP has eight key elements:

- Implementation of a substance abuse recovery management system (SARMS),
- Implementation of the dependency drug court (DDC),
- Availability of alcohol and drug treatment upon identification of a need,
- Increased participation of court-appointed special advocates (CASAs),
- Redefinition of the roles of key players within the dependency system,

- Use of settlement conferences,
- Use of family group conferences, and
- Improvement of the automated tracking system.

The SARMS provides immediate access to a substance abuse assessment by a substance abuse counselor, intensive case management, random urine testing, and bimonthly reporting to the DCS worker and the court on the client's progress. These services are provided to every parent with substance abuse allegations in the court petition to place their child(ren) in protective custody.

As a result of these changes, most DCS clients in San Diego County are in SARMS but do not participate in the DDC, a court program for parents who do not comply with court orders, which oversees treatment compliance. Clients who do not comply with SARMS requirements may volunteer to participate in DDC, subject to the approval of Judge Milliken. The DDC requires active participation in treatment, weekly court appearances during initial treatment phases, and compliance with court orders, including those that specify abstinence from alcohol and drug use.

While a parent participates in DDC, the child custody issues under the dependency court's jurisdiction are overseen by the dependency court and the judge who originally heard the case. Decisions regarding child custody, reunification, or termination of parental rights are handled in the regular dependency court and Judge Milliken does not make orders regarding child welfare issues in the DDC. However, he does report to the dependency court on client progress.

The DCRP policy group spent considerable planning time defining the roles and responsibilities of SARMS, DCS, treatment agencies, DCS County counsel, attorneys for the parents, attorneys for the children, and judges or court referees. The DCRP has provided for greater participation of CASAs to ensure that the best interests of children are represented.

Settlement conferences were instituted so that issues that may have been litigated in the previous system (e.g., compliance with treatment, results of urine test) are no longer brought to trial. These issues are now negotiated and parents are told early on that such issues are not grounds for contested litigation (e.g., chain-of-custody issues in urine testing). Parents' acceptance into the DDC requires that they agree not to contest findings by substance abuse treatment agencies and SARMS regarding their substance abuse recovery.

The county's DCS has implemented family group decision making conferences, in which the family is a primary stakeholder in developing the family's reunification plan (family group decision making processes are more fully explained in chapter III of this report).

The DCRP plans to improve its data system and evaluation capability. Judge Milliken views the following as critical ingredients in this system:

1. Case management,
2. Clear court orders,
3. Timely feedback to the court on treatment events,
4. Immediate access to treatment,
5. Consequences for noncompliance with treatment and violation of court orders, and
6. Positive reinforcement for achieving recovery milestones.

Underlying Values and Principles

The DCRP is based on the fundamental tenet that the ASFA time limits should be enforced. Judge Milliken asserts that clients benefit from "quick and sure sanctions" as an integral part of the recovery process itself. The project implementors maintain that parenting changes will not happen until parents are drug free long enough to address parenting issues. The program therefore makes family reunification contingent upon the parent's achieving sobriety. While the DCRP is based on the need for abstinence in all substance-abusing parents, some question that philosophy and suggest that the primary question should be whether these individuals can parent these children, rather than whether the mothers are sober.

The DCRP creators realized at the beginning that each brought different values to the planning process, and needed a great deal of time to talk through their perspectives. Consensus on the values and implementation of the project principles was facilitated by weekly meetings of the DCRP policy group, made up of department leaders from each of the participating agencies. These weekly meetings continued throughout the planning and early implementation phases. The group recognized that the stakes were high; they were not just creating a pilot project—they were changing the operations of the entire dependency system, which affected a large percentage of clients with untreated alcohol and drug problems.

The DCRP's power to demand treatment and abstinence has given rise to questions about whether the client's legal rights are adequately protected. Court staff say that program planners attempted to secure the buy-in of attorneys representing parents in dependency cases, who initially resisted efforts to gain client compliance. However now, according to Judge Milliken, these attorneys warn parents, "This judge is obsessed. If you are not sober in 30 days, he'll put you in jail, and if you're not sober in 6 months, he'll take your kids away." In Judge Milliken's view, his consistent rulings have convinced both the attorneys and their clients that the court is serious about compliance.

Daily Practice—Client Intake, Screening, and Assessment

During the investigation phase of a new child abuse report, the DCS social worker makes a determination about the possible presence of substance abuse. As in many California counties, social workers in San Diego use the Fresno risk assessment (appendix IX-A), which is a single line on the intake form that asks whether substance abuse is observable and requires the DCS worker to rate the extent of risk (low, moderate, high) of child abuse/neglect. If substance abuse is found, the dependency court judge recommends at the initial hearing that the parent be enrolled in SARMS, which is voluntary and occurs prior to the issuance of court orders specifying the terms of reunification.

SARMS is provided through a contract between the county department of health and human service's alcohol and drug division and Mental Health Systems, a local nonprofit substance abuse treatment agency. SARMS workers are employees of Mental Health Systems and serve all seven dependency courts in the county's four regional court sites. The county's contract stipulates that SARMS offices be within walking distance of the four dependency courts.

SARMS' goal is to place the parent in treatment within 2 days of a positive assessment.

SARMS workers aim to place the parent in treatment within 2 days of a positive assessment. SARMS functions as the gatekeeper to treatment, using 25-30 different providers under contract with the county. After a parent is referred to SARMS, a Mental Health Systems recovery specialist uses the Addiction Severity Index (ASI) to assess the client's alcohol- and drug-related problems and help determine what kind of treatment is needed; based on the results of the index, a recovery services plan (which used to be developed by DCS social workers) is developed that describes the parent's substance abuse recovery treatment program for reunification. At the court disposition hearing (21 days after the child is placed in protective custody), the recovery services plan requirements are incorporated into the dependency court reunification plan, and the recovery services plan becomes a formal court order. SARMS monitors the parent's compliance with the recovery services plan and reports to the court twice a month.

The court order for reunification is simple, intelligible, and includes an order for the parents to stay clean and sober for 6 months. Clients are asked in court if they understand the court order, i.e., that it orders them to comply with substance abuse treatment rules and remain clean and sober, with penalties if they do not comply. Drug testing is the basis for determining compliance and lying in court is grounds for removal from DCRP, with obvious consequences for the prospects of reunification.

If a client in SARMS is not in compliance with the court order (i.e., has a "dirty" urine test; fails to keep a treatment or drug test appointment, participate in treatment program activities, or appear for court hearings; violates program rules), the dependency court judge issues a warning. After a second case of noncompliance, the dependency court judge orders the parent to spend 3-5 days in jail, pay a monetary penalty, or both. After the third incident of noncompliance, an additional jail sentence and/or voluntary assignment to DDC is made. The client appears before Judge Milliken after serving the jail sentence and if they are accepted into the DDC, the client begins weekly appearances in DDC with Judge Milliken.

Daily Practice—Client Engagement and Retention in Care

SARMS is designed to make alcohol and drug treatment immediately available to parents through the assessment and case management roles of the SARMS worker. An estimated 90 percent of parents receive outpatient treatment, which is easier to access than residential care, which is more scarce and many not be geographically accessible to the parent (see appendix IX-B for the parent's agreement to participate in SARMS).

During the first 3 months of the case, the regular dependency court sees the parent at 30, 60, and 90 days. SARMS workers monitor the clients' progress in treatment through weekly face-to-face contacts, conduct random drug testing to monitor compliance with treatment, and report to the court on the 15th and 30th of each month (see appendix IX-C for a sample report form). The net effect of this policy is to ensure immediate access to substance abuse treatment, backed by incarceration for noncompliant clients, which reduces contested hearings in which parents might have argued that they were not given access to treatment.

Imposing immediate consequences for noncompliance is based, in part, on the county's experience with DCS clients, who are typically female, aged 25 years, have 2.5 children, and started to use alcohol and drugs at age 14 years. One social worker described the typical client as, "Sober, she is still 14". Once consequences were imposed, results improved. According to Judge Milliken, the ultimate mistake in dealing with adolescents is "to give them an order and then not follow through, but that was exactly what we were doing."

In addition to the court, the recovery specialists are responsible for engaging clients in treatment. These specialists must have at least 2 years of experience in the alcohol and drug field and State certification of addiction training, 18 units of relevant course work, or a B.A degree. The staff members are very diverse, and many have worked with and been in treatment with the program's providers.

Daily Practice—Services to Children

Treatment for children is not formally included in the DCRP. However, social workers may determine that services for the children are needed in particular cases and recommend to the court that the children be added to the case plan. Social workers receive training in providing services to children through DCS.

Treatment services to adolescents have been expanded since February 1998 and now include 4 adolescent detoxification centers, 40 residential beds, and 6 teen recovery centers that operate on a drop-in basis. All the programs for adolescents are "very compliance oriented," with sanctions for noncompliance that include time in juvenile hall and are similar to the sanctions for parents in dependency court.

Joint Accountability and Shared Outcomes

As of December 1999, 808 dependency parents were actively participating in SARMS, and 79 percent were in compliance with their recovery services plans. Attorneys appreciate that the project has had a positive impact. One attorney noted that parents with substance abuse problems gave up on reunification under the former system, but a stronger case can now be made on parents' behalf if they comply with the reunification plan. This attorney also pointed out that San Diego had been a "very litigious system" before the DCRP, but now, court resources can be reallocated more effectively because "we don't litigate every issue in the case." Attorneys no longer carry the burden of proving their case.

Judge Milliken has said, "We believe the results are at least twice as good as what we were getting from reunification before SARMS started operating." Although data are not yet available on treatment outcomes, the time from removal to permanent placement or reunification has been reduced from an average of 34 months to 12-13 months. Judge Milliken explained,

> We were trying to monitor and micromanage foster placements—even though we knew stranger foster care is developmentally damaging to kids because of their abandonment issues. Thirty-four months of temporary care before making a permanent placement decision means blowing it. Time matters for kids....If a parent isn't clean and sober at 12 months, the reasonable services issue is gone. We move immediately to the permanency hearing and, hopefully, adoption for the kid. We have doubled the number of adoptions—300 in 1996 to 648 in 1999.

Information Sharing and Data Systems

San Diego court and DCS staff acknowledge that if they could start all over, they would establish an adequate case tracking system from the outset. While the project compiles information, data are not always available in a form that would be helpful for substantiating the achievements of SARMS and the DDC. Although the ASI is used for initial assessment and treatment planning, its aggregate results are not readily retrievable for analysis of the total caseload. The county plans to expand the database capacity for aggregate analysis of alcohol and drug assessments.

As with other innovations in the alcohol and drug services (ADS)-child protective service (CPS) arenas, a new, layered system has been added to existing systems to track the effects of the innovation, as this could not be adequately captured by the older management information system.

Training and Staff Development

Training of social workers in alcohol and drug issues, including mental health issues and services, has been provided on a regular basis as part of new worker orientation. The first crosstraining of both substance abuse and child welfare workers was held in May 2000.

Some social workers believe that SARMS frees them to contact parents and work on family issues other than their substance abuse.

The county's own attorneys observe the effect of the DCRP on social workers, who used to fear returning children to their parents too soon. The twice-monthly reports on client progress have helped alleviate this fear. One attorney commented, "SARMS cuts down the workload for DCS social workers. Now they can do more social work concerning the other problems that led parents to the dependency court." The DCS social workers continue to visit clients monthly, guided by the progress reports.

The DCRP also has brought changes to treatment providers, whose workload has increased as they respond to additional telephone calls from SARMS staff and complete more paperwork. But county staff say that treatment providers support the project because of its positive results.

Budgeting and Program Sustainability

The program's $5.5 million budget came from the county's share of the substance abuse prevention and treatment block grant, family preservation funding, Medicaid for those services covered in California (primarily detoxification and services to pregnant and parenting women), State tobacco settlement funds, California's Temporary Assistance to Needy Families (TANF) program, and State general funds. Funds for case management and drug testing come from the county. The DCRP policy group is seeking additional funding from surplus TANF funds available at both the State and county levels. San Diego County is also considering an application for a IV-E waiver to use funding for treatment.

Working with the Courts

The San Diego DCRP's primary focus is on changes in the court system, so this chapter does not address working with the courts separately.

Working with Related Agencies and the Community

After clients graduate from SARMS or the DDC, they need aftercare support programs and safe and sober housing. As the Connecticut staff commented, returning clients to the environment in which they began using the substance may be detrimental to recovery. Some nonprofit providers have secured funding for apartments in which recovering parents can live with their children, resulting in some predictable "not in my backyard" issues. County staff are working with community groups to address these barriers. SARMS workers refer clients to other providers if they need mental health services.

Summary

In contrast with some other DDCs, San Diego's system is built on the comprehensive reform of the dependency court system for parents, rather than a pilot project for a relatively small group of parents. SARMS represents a commitment to case monitoring that goes well beyond most of the sites assessed for this report. Although the program needs a data system as comprehensive as the reforms, the reduction in time spent by parents and children in the system meets important goals set from the outset by Judge Milliken and his partners.

X. MIAMI/DADE COUNTY'S DEPENDENCY DRUG COURT

Background and Project Description

In Miami-Dade County's 11th judicial district, Circuit Court Judge Jeri Beth Cohen has led the establishment of the dependency drug court (DDC), which began operations in March 1999. Judge Cohen presides over one of three courtrooms in the juvenile court, and each handles approximately 300 dependency cases a year. Another Miami/Dade dependency court is a modified DDC that employs three addiction specialists who assist parents in substance abuse treatment. However, the modified DDC does not intensively monitor parents more frequently than the regular dependency court protocols require.

Judge Cohen came to the dependency court system in 1996 after spending 4 years in the driving under the influence (DUI) division of the court's criminal division. While in DUI court, Judge Cohen began an informal DUI drug court and, based on her success, obtained a grant from the Florida Department of Transportation for a program that monitors repeat DUI offenders; this program has become part of DUI probation. Through this work, Judge Cohen developed good relationships with community mental health and substance abuse treatment providers, which, along with her experience with alcohol- and drug-abusing individuals, became the basis for establishing the DDC.

Because relapse for substance-addicted individuals is so frequent and children and families entering the dependency system have so many needs, Judge Cohen determined that a system that might reunify children under the Adoption and Safe Families Act (ASFA) must provide intensive monitoring and a holistic approach to services. Services need to include not only substance abuse counseling and intensive and interactive parenting classes, but also competent psychological and psychiatric evaluations, trauma counseling, psychotropic medication management (if required), housing, vocational training, medical services and family planning counseling, and developmental assessments and interventions for infants and children, including counseling and substance abuse prevention classes for older children. As child welfare services (CWS) is overwhelmed with cases entering the system, Judge Cohen believed it crucial to assign dedicated and well-trained staff to the drug court and to keep the ratio of parents to caseworkers low. Moreover, the DDC needs sufficient funding to hire trained addiction and mental health counselors to work with the court.

Prior to setting up the DDC, Judge Cohen negotiated agreements with the regional office of the department of children and families (DCF) to dedicate three caseworkers to the DDC, and used funding from the Florida State legislature to support three addiction specialists, including a program administrator. Temporary Assistance for Needy Families (TANF) supports two additional addiction specialists who serve as a link between the court, parents, and treatment providers.

The addiction specialists conduct the initial screening for alcohol and drug (A&D) and mental health problems. The screenings include the Addiction Severity Index; the American Society of Addiction Medicine Patient Placement Criteria; the Beck Depression Inventory; a Readiness to Change scale; and the Mini-Mental State Examination, a screen for mental impairment.

To begin the planning process in 1998, Judge Cohen spoke extensively with and obtained materials from other dependency and family drug court administrators and judges. The resulting DDC protocol was adapted to the needs of Dade County. Next, Judge Cohen explained the DDC to approximately 30 substance abuse and mental health treatment providers and emphasized the need for collaboration. In the past, substance abuse treatment providers rarely informed the court of the progress of parents in the dependency system, and no clear policy for communication existed between substance abuse treatment agencies, DCF workers, and the court. Moreover, the courts were not aware of what was occurring in the substance abuse treatment facilities, including the residential treatment facilities where children were sent with their parents. Since Miami/Dade has a relatively large number of treatment programs for adult substance abuse, Judge Cohen was able to work with only those providers who agreed to cooperate with the DDC and provide accurate and detailed reporting.

Four maternal addiction programs provide substance abuse treatment to the majority of DDC parents, and one also provides residential treatment for both fathers and their children and families and their children. No programs in Dade County provide Spanish-language substance treatment for mothers and children, although one facility provides both residential and outpatient services for drug-addicted and dually diagnosed Spanish-speaking clients.

The treatment providers that work with DDC must sign a memorandum of understanding (appendix X-A) between the court and substance abuse treatment providers, which specifies reporting, screening, intake, and monitoring requirements for substance treatment providers. In addition, the programs agree not to release any client from residential treatment without consultation with the court and a detailed discharge and safety plan.

DDC addiction specialists, in conjunction with the DCF, develop a comprehensive case plan for the parents, and the substance abuse treatment providers jointly implement the plan with the DDC. Case plans are based on comprehensive psychological evaluations by court evaluation units, evaluations by DDC specialists, and client history. The plans include a wide range of services in addition to drug treatment, as well as services for all family members, including teenagers, children, infants, and non-substance-abusing spouses and significant others. The DDC treats the entire family as a unit and addresses all treatment needs. As a result, parents know that the court expects a complete lifestyle change that promotes the health and safety of their children.

Underlying Values and Principles

Judge Cohen explains, "A clean urine is just a small part of the process." While sobriety is one of DDC's primary tools for measuring readiness to change, its primary focus is on identifying and treating the underlying issues that cause and flow from the substance abuse. Most women in the DDC are victims of sexual and physical abuse in both their families of origin and their relationships. Their trauma, substance abuse, and poverty have prevented these women from developing nurturing parenting skills and resources for protecting their children. The DDC evaluates the entire psychosocial structure of the family and treats the family as a unit, while isolating negative influences on the family, such as violent, substance-addicted, and criminal spouses and paramours. The DDC evaluates and treats co-occurring mental health problems, based on the conviction that sobriety cannot be maintained in comorbid individuals who are not simultaneously treated for substance abuse and mental health disorders. Therefore, the DDC encourages the use of psychotropic medications for dually diagnosed parents.

Although the court recognizes that addiction is a relapsing disease, it is diligent in applying immediate sanctions for relapse and holds parents responsible for compliance with case plans. Under ASFA and Florida law, the court is required to reunite parents with children within 12-15 months. While this is a short time in the rehabilitation of chronic substance-abusing individuals, the DDC's time line is based on the needs of the child, not the parent.

The DDC encourages parents to take control over their bodies and requires them to seek family planning services as part of their case plans. Most women in the DDC have never used birth control (about which almost all the women want to learn more) or planned their pregnancies, are unmarried, and are not receiving child support from the biological fathers of their children. The court requires that all putative and named fathers be tested to determine paternity. Many of the women want tubal ligations but are unaware that Medicaid covers the procedure. Judge Cohen believes that dependency judges have an obligation to address birth control with parents in a realistic and noncoercive manner, although it is easier for female judges to discuss birth control with women.

The Center for Substance Abuse Treatment (CSAT) has funded a nurse from the University of Miami School of Nursing to work with the parents in the DDC. The nurse is on site at the courthouse on DDC day and meets with the parents throughout the week. Judge Cohen has found the addition of the nurse to be highly positive, because the nurse both counsels parents on birth control and assists them with a wide array of health problems, dental health needs, and psychotropic medications. The DDC also refers all adolescent girls and boys with parents in the DDC to family planning and AIDS counseling, and has assisted sexually active adolescent girls in obtaining birth control.

Judge Cohen finds it easier for female judges to approach some of the more intimate subjects with mothers, such as sexual abuse, domestic violence, and family planning. The mothers in the DDC have low self-esteem and suffer from guilt and shame, so they often develop a transference and codependency with the judge and the DDC staff, which is very beneficial at first. As the rehabilitative process progresses, the parents must learn to function without the structure imposed by the court, which is why a self-reliance phase has proven critical prior to graduation from the program.

The DDC's goal is to "provide another tool for A&D-abusing custodians who want to live a drug-free life so that they may assume the full responsibilities of parenthood while also enjoying the joys of parenting." To this end, the court seeks safe, permanent homes for children who do not remain with parents in residential treatment or at home, as soon as they enter the dependency court system. The court maintains stringent requirements for relatives who offer to provide foster care, based on its experience with intergenerational abuse and neglect. First, the relative must undergo a psychological assessment to ensure that placements are not affected by domestic violence, substance abuse, or child neglect. Second, the relative must provide a urine sample for drug testing. If other children have been placed in the relative's custody, the court may order developmental screens of those children. If relatives meet these requirements, they enter into an informal contract with Judge Cohen, and agree to align themselves with the court and the child, not the parent.

Daily Practice—Client Intake, Screening, and Assessment

The judge makes referrals to the DDC based on space availability and the complexity of the case, and participation in the DDC is voluntary. Since the DDC can accept only a limited number of parents due to the need for low client-to-staff ratios, the court gives priority to cases that require the most intensive services and monitoring, including parents who have given birth to several drug- or alcohol-exposed infants. Clients sign a DDC contract upon the advice and counsel of their attorneys, which sets forth what is expected of the parent and lists the sanctions for noncompliance. Parents are intensively monitored by the court and must initially appear before the court once a week, then twice a month, and, eventually, once a month.. Clients receive an appointment book to help them schedule and maintain their appointments.

During the final, self-reliance phase, the parent lives independently of the DDC for 3 months to help break the codependency between the client and the court, and to prevent relapse immediately before graduation. Clients generally spend 15 months in the program, and throughout their participation, must comply with drug testing requirements, maintain daily contact with their DDC specialist, and participate in Narcotics or Alcoholics Anonymous. To graduate from the DDC, a parent must have completed the case plan, obtained housing and employment, finished a parenting class targeted to substance-abusing parents, completed four motivational workshops organized by the DDC, and, most importantly, have regained custody of all of their children or agreed to leave some of their children in placements with a relative or other preadoptive arrangement.

Although DDC specialists conduct nine different screening and assessment protocols with the parents, a court evaluation unit provides in-depth psychological evaluations of the parents at both the inception of the case and before the parents graduate from the DDC to assess their degree of change. Psychiatric evaluations are also obtained when the evaluation team, the substance abuse treatment provider, the parent's family, or the parent herself suspect mental health issues. Judge Cohen believes that if dually diagnosed women are not treated with appropriate psychotropic medication and do not receive appropriate mental health and trauma counseling, they will continue to self-medicate with illegal drugs and alcohol.

Daily Practice—Client Engagement and Retention in Care

A primary focus of the DDC is client engagement, which occurs through contact with the judge, the DDC addiction specialist, and two clinical psychologists from the University of Miami's Department of Psychiatry. These psychologists have adapted an empirically validated engagement intervention tested by the National Institute on Alcohol Abuse and Alcoholism's Project Match for use in DDCs. Using a family systems approach, the psychologists supervise the DDC addiction specialists and assist them in engaging parents and their families in treatment and other services. The psychologists also train the staff and the court in a therapeutic model and visit the parents in their environments with DDC addiction specialists and DCF workers. The model is based on the theory that individuals heal through the development of healthy interpersonal relationships, so the psychologists help parents establish healthy and nurturing relationships with their families, significant others, other adults, and their counselors. The clinical psychologists stress that the main goal of the addiction specialists is to "help the parent successfully navigate and complete the phases required for graduation from DDC." The DDC specialists do more than case management and compliance monitoring, as they interact therapeutically with and advocate for the parents.

Judge Cohen is seeking funding to hire trained individuals to facilitate family group decision making in DDC cases. This model has already been used in the modified DDC in the dependency division, where family group conferencing facilitators work closely with addiction specialists to provide intensive case management.

The success of the DDC is dependent on a collaborative working relationship between the DDC specialists and the substance abuse treatment facilities. Clients sign consents to release information across agencies when they enroll in the DDC. Providers must submit weekly substantive progress reports to DDC staff (appendix X-B). In addition, the level and modality of treatment are agreed upon with the DDC staff, and no parent is released from residential treatment without a discharge and safety plan approved by the court. In the maternal addiction programs, providers are required to submit feedback to the court on the parent's parenting skills and the developmental progress of the children living in the facility. Judge Cohen has found it difficult to sensitize the providers to the court's need for information, but this has increased provider accountability, which, in turn, has enhanced the quality of services and outcomes.

The DDC tests urine for drugs and alcohol at the courthouse and obtains immediate results. Since the court cannot test randomly, all parents must complete a urine test twice each week. Several facilities obtain urine samples, which are covered by TANF. The Dade County Department of Transportation provides parents with bus tokens to meet their urinalysis requirements.

Recently, the DDC formed a partnership with Project Safe through the Dade County Children's Home Society. Project Safe has agreed to monitor DDC graduates for up to 1 year to ensure continued sobriety and safety for the children, and assist with the provision of additional services. Peer counselors from Project Safe encourage the parents to become peer counselors for addicted mothers who are beginning the process of recovery. The court and the DDC addiction specialists continue to monitor the parents on a monthly basis after graduation. The DDC encourages graduating parents who stay clean for at least 6 months to become mentors and sponsors for other parents in the DDC.

Peer counselors from Project Safe work with the parents to encourage the parents to become peer counselors for addicted mothers who are beginning the process of recovery.

Confidentiality is an ongoing concern. Parents are required to waive any confidentiality regarding substance abuse treatment and case plan compliance; however, information imparted to the DDC specialists that is nonessential to the legal process remains confidential. Providers are required to render to the court all psychological, psychiatric, or other assessments obtained during the intake process or treatment. At all hearings, DDC specialists, representatives from the treatment facilities, and dedicated DCF workers must appear in and provide the court with updated information. DDC specialists are trained not to consult with the judge outside the courtroom on specific cases in order to avoid *ex parte* communications with the judge.

An attorney represents all parents in the DDC and attorney-client privilege is not affected by the DDC. After a case is adjudicated and a case plan is signed, attorneys for the parents are not required to attend each status hearing on the case, which is initially held weekly (see appendix X-C for sample court orders). Instead, DDC specialists contact attorneys if their clients are noncompliant and liable to be sanctioned at the hearing.

Initially, defense attorneys were skeptical of the DDC because it imposed additional requirements and scrutiny on the parents. But since substance-addicted parents were rarely regaining custody of their children, defense attorneys agreed to approach the process with an open mind. The judge and DDC specialists met with the defense bar several times to orient them to the DDC, distribute the DDC protocol, and address their concerns. Attorneys were assured that the DDC would recognize parents' due process rights and keep them informed of any compliance problems. Over time, defense attorneys have come to view the program as an excellent support and have consistently requested entry for their clients into the program.

The DDC is strength based and uses praise as a motivator, but Judge Cohen believes that no drug court can be successful without swift and predetermined sanctions. The DDC uses graduated sanctions, ranging from community service hours to short periods of incarceration, usually on the weekend. Parents complete community service hours either at the treatment facility or the homeless shelter. Stepped up treatment is also a common response to relapse; however, counselors are careful not to equate treatment with punishment. Upon entering the DDC, parents sign a contract agreeing to jail sanctions of up to 15 days after several noncompliant events (appendix X-D). Parents are not held in criminal or civil contempt, and no adversarial hearing is held prior to ordering the jail sanction. Imposing a jail sanction without a prior hearing was affirmed by the Third District Court of Appeals. Judge Cohen has only used the jail sanction five times (in approximately five percent of cases) in the past year, when the court had already tried less severe sanctions. The jail sanction changed noncompliant behavior in only one instance.

Daily Practice—Services to Children

The primary focus of the DDC is on safety and permanency for children. The DDC offers a broad array of services to children from infancy until 18 years of age. DDC collaborates with the Linda Ray Center, an early intervention center for substance-exposed newborns, to provide case management and services to children aged 0-3 years and their custodians, including primary medical care and family skills training. The center also offers a center-based and home-based program, and collects data on the developmental progress of children in both programs. Through a CSAT grant, the center performs assessments every 6 months on all substance-exposed children aged 0-3 years whose parents are participating in the DDC, using the Ages and Stages Assessment tool.[1] The center screens and refers children with significant developmental problems to the appropriate services. Language, socioemotional, and motor skill delays have been identified in this population, and early intervention leads to substantial improvement in functioning.[2] After graduation from the center, children are referred to Head Start.

The Linda Ray Center and the DDC have obtained a grant from the Center for Substance Abuse Prevention (CSAP) for Strengthening Families, a 14-week, multicultural, interactive parenting skills program designed specifically for substance-addicted parents and their children that was developed with a group of local providers. The program offers culturally sensitive and effective parenting strategies designed to decrease substance abuse by improving parent-child interactions. The first hour of each 3-hour session consists of a joint dinner for parents, extended family members, and children. During the second hour, parents and children separate, and the adults concentrate on some aspect of parenting. In the third hour, parents and children reunite and complete a joint activity in which parents use the skills learned in the previous hour. Although the intervention is geared to younger children, activities geared to adolescents have been added.

Many parents have been unable to use the parenting techniques taught in the session for more than a few minutes at a time; they cannot meaningfully interact with their children for any length of time. Accordingly, the program has assigned one-on-one facilitators/instructors to several parents and added a nurturing families course that is mandatory prior to participating in Strengthening Families.

The Linda Ray Center's extensive involvement with the family helps the court obtain a much more realistic and comprehensive understanding of the parent's interaction with the children prior to reunification. The center also provides the DDC with information on the extended family system and the interaction of family members with the children and each other. The family trees and genealogies that the center prepares on each child's family are extremely useful to the court in understanding intergenerational violence and substance abuse, and choosing appropriate caretakers for the children. Center staff appear at all court hearings and are an integral part of the DDC team. The center also oversees and reviews the child services offered by the maternal addiction programs, and has encouraged the programs to hire competent early childhood directors, implement quality learning programs, and create child-friendly environments at the facilities.

All children aged 3 to 18 years with parents in the DDC receive psychoeducational evaluations from psychologists who either work for the court or contract privately with DCF. The testing results assist the court in understanding the educational levels of the children, their degree of exposure to violence and other trauma, and the therapeutic interventions required. All teenagers are required to attend family planning and HIV/AIDS counseling, as well as ALATEEN and/or group counseling. Family and individual counseling helps the children understand their parents' substance abuse and their own increased risk for substance abuse. If any of the children are believed to have a substance abuse problem, the court includes the child in the DDC process and monitors him/her along with the parent.

Joint Accountability and Shared Outcomes

A basic measure of success for parents in the DDC is moving to permanency within 12-15 months, reflecting the DDC's goal of faster and more accurate judgments as to which parents will not succeed in substance abuse treatment. The University of Miami evaluators have shown that evaluation efforts should be part of a drug court from its inception, to ensure that interventions are effective. The drug court should employ experienced evaluators who are familiar with drug courts, child abuse, and the court process. In addition, information systems should be established to provide useful data to the evaluators. The evaluation must identify clearly the outcomes to be measured, including length of time to permanency for the child, improved parent-child interactions, and the parent's ability to nurture and provide a safe environment for children. This last outcome is difficult to measure, but crucial to assess before reunification occurs.

During its first year, the DDC enrolled 92 parents. Of these parents, 15 refused to participate and 77 agreed to participate, but 10 dropped out and their cases went to termination of parental rights. The remaining 67 cases represented 212 children, of which 84 were under the age of 4 years. About 80 percent of the parents selected for the DDC were women. The 67 parents now in the program represent 3.3 percent of the more than 2,000 current case files (as of May 2000) in the formal child protective service (CPS) system each year, underscoring its status as a demonstration program.

In May 2000, the first DDC class of 13 graduated. All the graduates, except one, were women, and only four fathers are currently participating in the DDC. DDC officials have found it difficult to engage men in the DDC process, and the men who have been successful in substance abuse treatment were married with strong family support. Judge Cohen emphasized that it is more difficult to establish relationships with men than women, because of the importance women place on positive relationships with their counselors, children, and the court. The DDC has also found that the larger the sibling group, the more difficult it is for the parent to stabilize sufficiently to regain custody of all the children. Judge Cohen points out that failure to comply with the DDC is also a success if the parent's lack of commitment is determined early and the children can be moved to permanency expeditiously.

Failure to comply with the DDC can also be considered a success, if a parent's lack of commitment is determined early and the children can be moved to permanency expeditiously.

Information Sharing and Data Systems

Florida is one of a few States that include information about children in their basic dataset on clients in the substance abuse treatment system. This enables the Miami DDC to rely upon the substance abuse data more than most other systems, and the court also keeps its own data on clients served by the DDC. However, managing the data has proven difficult due to the lack of an adequate computer program to capture the data. Unfortunately, since the data are collected manually by DDC staff, they may not always be complete or accurate. This has greatly hindered the DDC's attempts to obtain accurate empirical data for assessing the program.

The University of Miami's exit interviews have proven extremely valuable in evaluating the program from the parents' perspective. In addition, CSAT analyzed the program based on program data and information gleaned from the screening instruments and interviews with program participants (including lawyers, service providers, guardians *ad litem*, and the court). The Linda Ray Center is also collecting outcome data from the Ages and Stages assessments and the Strengthening Families intervention.

Training and Staff Development

The DDC is committed to training all stakeholders in the system. The court closes twice a year to present educational seminars to court and DCF personnel, lawyers, and other interested parties. In one session, national experts focused on substance-abusing women and substance-exposed newborns, and another was to focus on trauma and relapse. The DDC is a demonstration site for other courts interested in implementing a DDC, so judges and court administrators from around the country often visit. Finally, Judge Cohen and other DDC staff lecture around the Nation on different aspects of DDC and therapeutic jurisprudence.

Budgeting and Program Sustainability

TANF and legislative funds support the DDC addiction specialists. The DDC obtained $200,000, for its first year, and $150,000 subsequently. The State court system is somewhat reluctant to fund specialty courts, which is how drug courts are viewed by some court administrators. Nonetheless, the DDC has requested funding from the Florida legislature for nine new addiction specialists to staff all three courtrooms.

Working with the Courts

The Miami/Dade DDC was initiated through the court and this report therefore does not address working with the courts separately.

Working with Related Agencies and the Community

Although clients are screened for mental conditions, one of the most difficult challenges for the DDC has been convincing substance abuse treatment providers to identify and appropriately treat dually diagnosed clients, either on site or at another facility. While Dade County is relatively rich in substance abuse treatment services, Judge Cohen argues that these services are fragmented and generally do not address the mental health component of treatment. Through education and collaboration, the substance abuse treatment facilities have begun to work more holistically with parents in order to meet all of their needs. These facilities have thus formed partnerships with the public health nurse, the substance-exposed newborn program, and victim's services for trauma, sexual abuse, and domestic violence counseling. In addition to the nurse who works with the DDC, the DCF recently provided a master's level social worker to the DDC to assist with case management for dually diagnosed cases.

Summary

The DDC has helped familiarize the court and DDC staff with the psychosocial and substance abuse histories of parents in the DDC. Through close collaborations with other system players, the DDC has obtained comprehensive information on the developmental and emotional needs of the children of DDC clients, and the quality of parenting that each family structure is capable of providing. Given the complex problems that confront DDC families, no single agency can provide the comprehensive supervision, services, and support they require to regain and maintain custody of their children within ASFA guidelines. As Judge Cohen notes, "If we have learned one thing from DDC, it is that substance abuse is only one aspect of the psychopathology that impairs families in the dependency system." Without true collaboration and commitment by all of the players involved with the family, treatment services will be fragmented and will not contribute to the rehabilitation of the impaired family.

Finally, DDCs represent a new concept in therapeutic jurisprudence. The DDC protocol must be flexible and based on strategies that have been tested and proven to be effective. The Miami/Dade DDC has increased the morale of all system players, especially the DCF case workers who, for the first time, see the dependency process contribute to making families healthy and creating safe, permanent homes for children.

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XI. FINDINGS FROM THE CASE STUDY SITES

Underlying Values and Principles of Collaborative Relationships

The case studies make clear that the different underlying values in the child welfare and substance abuse treatment partners can lead to problems that impede collaborative relationships, unless these differences are addressed. The Connecticut, Sacramento, and Cuyahoga County sites developed formal statements of principles that guided their innovations. Other sites expressed their values less explicitly, but the values are apparent in the goals of the models. Even when reforms originate in an individual system, such as the dependency drug courts in San Diego and Miami, values need to be negotiated and discussed among the courts, child welfare, and substance abuse treatment agencies. External events, such as the new HR 484 legislation in Ohio that specifies that parent rights can be terminated after two failed substance abuse treatment episodes or the deaths of young children in Sacramento County and other sites, can also force agency discussions to address values.

Daily Practice—Client Intake, Screening, and Assessment

The seven sites visited for this report have developed innovative approaches to the initial challenge of determining risk and assessing families' needs, with extensive use of shared and outstationed substance abuse treatment agency staff for indepth assessments. In addition to changes in screening and assessment, most of the sites have tried to understand better the characteristics of parents who are clients of each type of system. Successful sites have documented the extent of overlap between child welfare services (CWS) and Temporary Assistance for Needy Families (TANF) systems and the relative need for substance abuse treatment of the clients in each system. The intake and referral links to TANF made by some of the sites have resulted from expanded use of TANF funding for this population, which is often a signal of a site's willingness and ability to accept new partners and new resources.

There are a range of screening protocols and instruments employed by the sites. The critical issue is that each site determined the type of philosophy that underscores their screening and assessment approach. Some sites choose to cast a wide net in their approach and refer parents for more comprehensive assessment by certified alcohol and drug counselors based on a minimal threshold of indicators of substance abuse problems. Other sites use a more standardized assessment protocol in conjunction with the CPS worker. Finally, some have provided a range of options for social workers in an effort to ease their workload and to assist their efforts to identify and refer as many parents as needed. Although the sites use different screening and assessment tools, all use the tools to identify cases and determine their severity in order to identify levels of risk and appropriate services.

Daily Practice—Client Engagement and Retention in Care

Retention efforts in all seven sites involve frequent therapeutic contacts, individualized treatment plans, or both. For example, Cuyahoga County ensures that timely and frequent contact is established between the START workers and the mother immediately upon acceptance to the program. Connecticut now screens for barriers to treatment, such as lack of transportation, child care, and health care to ensure that treatment plans address these barriers. Miami extensively uses a comprehensive assessment approach to tailor the services needed by parents to their individual needs. In addition, they provide frequent contacts with parents using DDC graduates as mentors.

Daily Practice—Services to Children

Of the seven sites included in this report, Connecticut and Miami have devoted the most attention to developing intervention programs for children of substance abusers in the child welfare system. Connecticut's efforts have come from both the Department of Children's and Families and substance abuse treatment service systems. Their Department of Mental Health and Addiction Services is one of the few statewide substance abuse treatment systems to have established psychoeducational groups for children of substance abusers. One lesson learned by the Connecticut site is that foster parents must have ready access to the intervention groups.

Joint Accountability and Shared Outcomes

For the most part, at the time of the site visits, the sites were still struggling to develop outcomes that were shared across the participating agencies. The dependency drug courts have made clear what standards they will use, based on Adoption and Safe Families Act (ASFA) time limits, to assess the effectiveness of interagency efforts. In Connecticut, the phase II agreements include a move toward shared outcomes. The Sacramento site's combined use of a systems of care approach to treatment monitoring and its links to the State's Treatment Outcomes Performance Pilot Study make it one of the strongest models in the Nation of accountability for outcomes in a county-run system. But all sites were continuing to work on interagency outcomes although child welfare agencies and substance abuse treatment agencies tended to focus only on their own traditional outcomes.

Information Sharing and Data Systems

In general, the sites use existing informed consent procedures as early as possible in the client's intake process and have enlisted attorneys' help in enrolling parents in treatment. Depending on the site, either the child welfare or the substance abuse treatment agency is responsible for obtaining clients' consent for the release of confidential information. Each site has developed information-sharing protocols with the dependency courts. After developing their program model and gaining the trust of partner agencies, none of the sites found regulations protecting confidential substance abuse treatment information to be a barrier to collaborations among agencies.

While databases are necessary for determining whether a program is succeeding and identifying areas for improvement, only the Connecticut and Sacramento sites had an adequate information system. In Connecticut, the treatment providers' database can be linked with the State systems, which allows the Connecticut site to identify the dropoff points, where clients fail to keep their appointments. On the basis of this information, this site has designed a second phase aimed at increasing retention. The remaining sites would like to acquire this technology.

Training and Staff Development

Training, like screening and assessment, has been undertaken by all the sites. Some sites have integrated substance abuse training into their existing worker training programs. Others have developed specific curricula and approach training from a cross-systems perspective in which workers from CWS and substance abuse treatment jointly participate in the sessions. Connecticut and New Jersey report that significant cross-training has occurred informally as the outstationed substance abuse specialists interact with CWS workers on a daily basis. Sacramento's efforts in this arena are noteworthy and the most ambitious. They offer three level of training: basic education about alcohol and drugs for all staff, screening, intervention and referral for caseworkers, and group facilitation skills addressing the specific needs of the CPS population for social workers and substance abuse counselors.

Budgeting and Program Sustainability

All of the sites have sought and secured funding from a range of Federal, State, local, and private funding sources. TANF funds, in particular, have been used to supplement staffing needed for child protective services (CPS) cases. The difficulties of combining funding from multiple sources are substantial, but most sites have accomplished this with support from their budget staffs. Few of the sites, however, have developed multiyear funding plans based on an explicit strategy for sustaining the funding. Instead, most continue to pursue whichever time-limited grants are available in a given year.

Working with the Courts

All sites, by definition, have relationships with the courts, given the critical role of the courts in adjudicating CPS cases. Two of the sites studied are based in court, the substance abuse recovery management system (SARMS) program in San Diego County and the dependency drug court in Miami. Naturally, these two sites represent the models in which the court system is most prominent. However, the Sacramento County site has sought the active involvement of the criminal justice system and the courts, and has provided training to the court's staff. It is also implementing a new dependency drug court.

Working with Related Agencies and the Community

All of the sites studied have developed new resources for substance-abusing parents and their children by creating links to agencies that provide housing, mental health and domestic violence, and other supportive services. In Jacksonville, Sacramento, and other sites, active community partners have also provided child welfare prevention services and some, but not all, of these organizations, have started to include substance abuse treatment services.

Child care has proven to be a problem for parents enrolled in day treatment programs in the Connecticut site. Most sites have sought help from outside agencies for housing and mental health services. The Miami site has developed an extensive network that includes mental health facilities, primary healthcare providers, parenting classes, vocational guidance, family therapy, housing, and motivational or spiritual help.

Summary

Although the programs of the Cuyahoga County, Jacksonville, and Miami sites are on the scale of a pilot or demonstration project, they still exemplify important innovations in services to child welfare families with substance abuse problems. All of the sites have developed successful ways of addressing the problems that can be expanded within their own jurisdictions and replicated across the Nation.

HIGHLIGHTS OF PROGRAM ELEMENTS ACROSS SITES

	Connecticut	New Jersey	Sacramento	Cuyahoga	Jacksonville	San Diego	Miami
Underlying Values	Fifteen guideposts developed by commissions as basis for program improvements		Detailed principle statements agreed upon by stakeholders at project inception	12 tenets agreed upon over 3 years of program development	Focus on the community's role through the community partnership	Adherence to Adoption and Safe Families Act (ASFA) deadline	Healthy functioning of whole family and permanency for children
Daily Practice—Screening and Assessment	Screening by child protective services (CPS); substance abuse assessment by statewide substance abuse providers	CAGE for screening and specific substance abuse tool for assessment	CPS trained for preliminary assessment or referrals to alcohol and drug agency for assessment	Triggered by substance-exposed newborn assessed by team of CPS and family advocates	CPS investigation workers refer to outstationed substance abuse counselor for assessment	CPS determines issue, court requires assessment by substance abuse counselor	Judge identifies most difficult cases and refers to drug court
Daily Practice—Client Engagement and Retention in Care	Intensive case management to improve show rates	Joint treatment plan developed by CPS and substance abuse treatment staff	Match clients to specific treatment	Recovery coaches, small caseloads of 15, intensive contact	Motivational counseling	Incentives and sanctions at each stage	Regular monitoring by judge
Daily Practice—Services to Children	Groups for children of substance abusers in regional offices	Referrals for children's services	Youth groups in neighborhoods	One staff member coordinates care for children	Children of substance abusers groups; youth counseling	Referrals for children's mental health services	Intervention center with special services for children of substance abusers

HIGHLIGHTS OF PROGRAM ELEMENTS ACROSS SITES	Connecticut	New Jersey	Sacramento	Cuyahoga	Jacksonville	San Diego	Miami
Joint Accountability and Shared Outcomes	Child welfare and substance abuse agencies negotiated shared outcomes in phase II		Evaluation of project assessed child welfare and substance abuse outcomes, ongoing monitoring of child-specific indicators	Evaluation of project assessing child welfare-related outcomes			Dependency drug court shares responsibility with child welfare and substance abuse agencies for achieving permanency for children and recovery for parents
Information Sharing and Data Systems	Clients referred to substance abuse agencies with separate behavioral health database		Treatment providers track child data with amendments to substance abuse database	Outside evaluators created evaluation database			
Training and Staff Development	Preservice training modified, in-service crosstraining	3 days for CPS workers, 6 days for home visitors	Three levels of training: 4 days for all human service workers, 8 for case workers, 12 for group interventions	Staff trained in chemical dependency and team building	Three-day joint CPS-substance abuse treatment training	Crosstraining of CPS and substance abuse workers	Court operates semiannual training sessions and ongoing orientation sessions
Budgeting and Program Sustainability	Multiple funding streams of treatment providers through CPS and substance abuse agencies	Multiple funding sources, including State commitment of general funds	Multiple funding sources coordinated by county agency, including initial foundation support	Multiple funding sources through regional board and initial foundation support	Temporary Assistance for Needy Families (TANF) funding for substance abuse treatment	Multiple funding sources, including substance abuse services, child welfare sources, and TANF	TANF funds for addiction specialists and treatment services, State legislative funding through Administrative Office of the Courts

HIGHLIGHTS OF PROGRAM ELEMENTS ACROSS SITES

	Connecticut	New Jersey	Sacramento	Cuyahoga	Jacksonville	San Diego	Miami
Working with the Courts			Court training, outstationed substance abuse workers, in planning stages for dependency drug court			Dependency drug court model	Dependency drug court model
Working with Related Agencies and the Community	Focus on child care and phase II emphasis on comprehensive service delivery through collaborative networks	Transportation and other services provided through referrals from case managers	Criminal justice agencies involved, links to mental health and other services, use of community services assessed in data system	Housing links established, referrals to other agencies	Transitional housing and referrals to other agencies	Mental health referrals and case management through child welfare services	Formal linkages to multiple community agencies for services to whole family

XII. LESSONS FROM THE CASE STUDIES

This section provides a discussion of the implications of the seven case studies.

Underlying Values

Matching Allocations to Need

All seven sites have had to address the allocation of treatment slots, especially since only about one-third of all individuals admitted for substance abuse services nationally are women. Some sites have developed a broad-based, multiyear funding strategy to expand total funding so as to increase the overall number of treatment slots. But funding is never sufficient to support all the treatment slots needed, and decisions must always be made explicitly or implicitly (by simply using the previous year's allocation system) on the basis of the impact of substance abuse treatment on both parents and their children. A process is needed to ensure that allocations match need and reflect the impact of decisions on future generations.

Practitioners in substance abuse, welfare, and child welfare service (CWS) agencies tend to disagree about responsibility for compliance with substance abuse treatment.[1] Some regard compliance with treatment as entirely up to the client, while others believe that compliance depends on agencies' use of the most coercive powers available to them. Currently, an essentially centrist position appears to be emerging that the clients and institutions share responsibility for substance abuse treatment compliance. Addiction is a disorder in which chemistry, genetics, and personal behavior play a part.[2] Thus, welfare and child welfare agencies should demand more of clients if sufficient substance abuse treatment slots are available. Ultimately, this choice among approaches is not a programmatic or clinical issue, but one of values, as each agency needs to make its policies on "second chances" clear to its staff and clients. At the same time, agencies must recognize that when children are involved, the clock is always running, and both sets of agencies need to be prepared to respond to courts' questions about clients' progress.

Since precise clinical judgments are rarely sufficient to make clearcut decisions, value judgments about clients will always play an important role in permanency decisions. Making clear the basis of those value judgments seems better than making *ad hoc* decisions for every client or pretending that the answers can come from hard science, assessment tools reduced to software, and a quantitative determination of clients' prospects for recovery. In several of the sites studied, the values debates are visible, including those about abstinence, relapse, harm reduction, and child safety under the new time limits.

Roles of the Partners

The Cuyahoga County policy and practice innovations underscore the importance of considering substance abuse treatment agencies as equal partners with child welfare agencies,[3] even though most literature on this subject focuses primarily on the role of child welfare agencies. The Cuyahoga County Sobriety Treatment and Recovery Team (START) begins to act once a substance-exposed birth (or positive prenatal toxicological screen) is detected. The extremely low client-to-worker ratio (15:1) is justified by the need for a full-family approach to continuous case management and client engagement, including accompanying clients to initial substance abuse treatment visits. Negotiations between child welfare and substance abuse treatment providers have resulted in adjustments to each side's position on relapse, with a general working agreement on exchange of information about treatment progress that does not breach confidentiality requirements.

In Cuyahoga County, the trigger is a positive toxicological screen, but the response comes from both START and the substance abuse treatment agency. Without the treatment agency, the START worker could only refer clients to ever-increasing waiting lists; without the sustained client engagement support of START, the substance abuse treatment agency would probably lose some of the parents who need its services most.

Responding to Prenatally Exposed Births

Rapid response to a positive screen is central to the success of programs serving the children of substance abusers. Many hospitals, however, do not have clear screening policies. In arguing for drug screening at birth, some practitioners point out that screening for sexually transmitted diseases, phenylketonuria, and HIV/AIDS and other infectious diseases has become routine in many hospitals. Since hospitals provide services to patients in response to screening results for these conditions, they should also routinely screen all newborns for substance exposure and provide services when such exposure is detected. Moreover, these practitioners argue, interventions should begin as early as possible, during prenatal examinations in which urine samples are routinely taken.

A task force of healthcare experts recently reviewed screening practices for the 4 million children born annually[4] and found that State and hospital practices varied widely in the congenital defects they test for and how they address privacy and consent issues. The report concluded, "The definition of comprehensive newborn screening is changing rapidly and public health programs may not be keeping up."

Screening newborns for substance exposure is ultimately another issue of underlying values—society, communities, and hospitals need to decide which conditions affecting children are so important that those conditions, but not others, should be screened for at or before birth. Given the lack of consensus on this question, child welfare or substance abuse treatment systems by themselves are clearly unable to resolve it.

The Cuyahoga County experience shows that substance-exposed births cannot be treated as isolated events, but need to be monitored in the context of the family's functioning and the child's development. Restricting the policy question to how to respond to a positive toxicological screen narrows the policy focus too much, and ignores the full range of parental responses to services. Equally important are issues of accessibility and availability of the full range of services needed to intervene decisively with that child and family. Success will flow from a combination of the most comprehensive, family-focused programs available from substance abuse treatment agencies, combined with the fullest client engagement efforts possible from CWS providers.

Recommendations for policy changes in this difficult area must also directly address the possibility that broader drug testing would serve as a deterrent to prenatal care in some substance-using parents. However, the risks of policy changes that require broader screening seem at least comparable to the risks of the current system in which prenatal substance exposure is almost certainly underdetected.[5]

To improve the connections between child welfare and substance abuse treatment agencies without addressing prenatally exposed children, even though they represent only a small proportion of children affected by substance abuse, is to ignore the profound underlying issues raised by substance-exposed births. Responding to substance-exposed births requires a more comprehensive perspective on the larger issues of all substance-exposed children, whether they are exposed *in utero* or in their family environments.

Daily Practice—Client Intake, Screening, and Assessment

A recent review of CWS assessment practices stated a minimal position with respect to substance abuse assessment:

> These [supplemental tools] may be tools that partners need to access occasionally, but they are not part of the usual assessment process. For example, they may include tools for assessment of child and family functioning, domestic violence, and substance abuse.[6]

When two-thirds or more of the caseload exhibits the condition being assessed, "occasional" efforts to detect that condition are clearly insufficient. Fortunately, the sites visited for this report disagree with this statement, and each has made screening and assessment for alcohol and drug problems routine.

Daily Practice—Client Engagement and Retention in Care

The need to engage clients is evident in the "no-clock" cases, in which an investigation substantiates abuse or neglect but the agency decides to keep the child in the family's custody and monitor and/or provide supportive services. In some sites, practitioners do not regard the more serious cases as those in which children are removed and parental rights may be terminated, but as those in which the children stay in their homes. "That's where I worry most about child safety," said one CWS supervisor. These cases that are not part of the dependency court through family reunification programs or others that receive court-authorized monitoring, and the risk and severity of these "no-clock" cases need to be compared to cases in which children are removed.

Focusing only on cases in which the Adoption and Safe Families Act (ASFA) clock is running misses an opportunity for prevention and earlier intervention, in the view of some CWS teams interviewed. The Jacksonville site's two-track system formalizes the effort to involve the community in family support. In Connecticut, the emphasis on returned children is explicit and guides some resource allocation to linking parents with needed substance abuse treatment. Each jurisdiction needs to make its own choices as to the emphasis placed upon children and families in different situations. However, children returned home after a CPS substantiation—the "no-clock" cases—may still face significant substance abuse problems and parents may need substance abuse treatment.

Daily Practice—Services to Children

Some experts on children of substance abusers (COSAs) have called for a diagnostic category of "chronic trauma of childhood" for this high-risk group.[7] They propose that interventions be designed to address the accumulated effects of multiple incidents of childhood trauma throughout a person's lifetime. The Children of Alcoholics Foundation refers to children who experience both parental substance abuse and family violence as "twice at risk" for significant developmental delays and substance abuse problems. However, not all COSAs experience multiple traumatic events or detrimental effects due solely to their parent's substance use disorder. In fact, evidence shows that many COSAs are resilient, high-functioning individuals.[8] and the effects of early trauma may not be irreversible. In fact, family-based interventions have proven effective at increasing children's protective factors and reducing risks.[9]

Much has been learned about barriers to development and maladaptive coping skills in COSAs. For example, broad-based prevention programs are not generally sufficient to effectively address the needs of COSAs. The usual children's mental health programs and systems of care initiatives are equally ineffective, as they mainly target children who are suffering from severe emotional and behavioral disorders, and most COSAs do not have this severity of emotional disturbances. Most practitioners in this field agree that a shortage exists of trained professionals who understand the clinical problems faced by COSAs.[10]

CWS children whose parents are substance abusers are often the initial impetus for forging a link between child welfare and alcohol and drug abuse agencies that cannot reach agreement in other areas. The substance abuse prevention and treatment fields have specific expertise to offer child welfare services for these children.

The National Association for Children of Alcoholics has developed and disseminated core competencies for healthcare providers in serving children and adolescents affected by substance abuse (appendix XII-A). In addition, the Children of Alcoholics Foundation has issued guidelines for developing support groups for young people from substance-abusing families.[11] These are valuable resources for sites that are interested in serving this population.

Joint Accountability and Shared Outcomes

Common outcomes measures for tracking clients to determine whether they are complying with substance abuse treatment are critical elements of results-based accountability. But many sites cannot track clients consistently yet. Although they hope to build evaluation systems after establishing their services, this delay in building the data infrastructure needed for monitoring implementation can cripple their innovation, as some sites have found. Building new AOD-CWS links without measures of the outcomes of those linkages is like installing a heating and cooling system without any thermostat to measure and regulate the temperature.

Federal agencies concerned with substance abuse treatment and child welfare services do not require interagency outcome capacity, which has reinforced the tendency toward isolated information systems and unidimensional development of outcomes measures. A welcome exception, however, is the Center for Substance Abuse Treatment's (CSAT's) Treatment Outcomes and Performance Pilot Studies Enhancements (TOPPS) II program, which includes child welfare-specific indicators in the outcome monitoring systems of its State projects. These may eventually develop the capacity for ADS-CWS programs to monitor treatment outcomes.

Information Sharing and Data Systems

Confidentiality

Confidentiality could fall under any of several items in the 10-point framework of this report. It is discussed under information sharing and data systems. However, it is a major component of client engagement because an agency cannot engage a client who is not referred to it or does not know that the agency exists, nor can it determine the need for more intensive efforts if communication across systems is weak.

The legal issues of confidentiality are complex, arising from at least four separate bodies of legislation:

1. Substance abuse treatment privacy requirements (42 CFR),
2. Mandated reporting requirements under Federal and State CPS laws,
3. Client-therapist confidentiality statutes, and
4. Federal legislation governing research programs and data collection on human subjects.

The new ASFA timetables heighten the importance of confidentiality issues, because access to timely information on a client's progress, or lack of progress, may affect court outcomes.

The Code of Federal Regulations (42 CFR 2.1, *et al.*) established the confidentiality of treatment records and specifies five exceptions that are pertinent to this discussion:

- Reported child abuse and neglect,
- A patient's consent to release confidential information,
- A court order,
- Audit and evaluation, and
- A qualified service organization agreement.

No site appears to have found confidentiality to be a persistent barrier to serving families. However, confidentiality is the one issue that is consistently raised in initial conversations by different sites. Based on the experience of these sites in addressing the confidentiality issue, it would appear that citing confidentiality as a barrier to cross-system collaboration may actually indicate underdeveloped relationships among child welfare agencies, substance treatment agencies, and the court systems. The sites that had progressed furthest in developing these linkages appeared to have the least difficulty with confidentiality issues.

Confidentiality is a subset of effective communication issues. Based on the lessons from these sites, each site needs a detailed communication protocol that specifies efficient three-way exchanges of information across CWS, substance abuse treatment agencies, and the court. While Federal and State laws can facilitate communication, how systems exchange information must be determined by local policymakers, administrators, and practitioners from all three systems.

The case studies make clear that determination of the communication protocol must be made locally, because confidentiality plays out differently in each site. The specifics of the communication protocol must be determined, in part, by the

Each site needs a detailed communication protocol that specifies efficient, three-way exchanges of information across CWS, substance abuse treatment agencies, and the court.

agency that employs the substance abuse treatment counselor, which may be a private nonprofit or public child welfare agency.

While Federal and some State laws are specific barriers to information exchange, this review did not find that Federal or State provisions create unsurmountable barriers to collaboration. Informed consent can be time consuming to obtain and enforce, but the evidence from these sites suggests strongly that child welfare, substance abuse treatment agencies, and the courts must plan in advance for communications; develop a communication protocol for exchanging information across all three systems; and, if a communication system is in place and a parent chooses not to allow the exchange of information or rescinds consent, then the CWS agency and courts must make their decisions without knowledge of the parent's treatment experience. In practice, parents who are compliant and progressing in substance abuse treatment rarely withhold this information from their child welfare workers. Therefore, it is reasonable to assume that parents who rescind or fail to grant consent are not doing well in substance abuse treatment.

Mapping the Dropoff Points

The best projects illustrate that two ingredients are needed to address client engagement:

- A clear treatment philosophy that includes techniques for engaging clients; and
- A sufficiently strong tracking system to determine where clients drop off, i.e., the points at which clients are most likely to drop out of the system by missing appointments or refusing treatment.

If an agency does not know the points at which it is losing its clients, its philosophy toward client engagement and retention in substance abuse services may not matter much. The framework needs strong overlap between client engagement and information systems.

The Connecticut site has determined the existence of at least six dropoff points:

1. A CPS worker makes an initial judgment that abuse issues are present and records that judgment.
2. The client is referred to further screening and/or assessment by a substance abuse treatment specialist.
3. A specialist documents substance abuse problems and refers the client to a substance abuse treatment agency or prepares a treatment plan.
4. The client enrolls in treatment.
5. Client compliance with and progress in treatment are recorded.
6. The client completes treatment and makes progress in reunification goals.

This represents the clearest list available among the sites for tracking drop offs. The Connecticut site's tracking system, which should be part of every ADS-CWS implementation plan, shows how a large number of clients needing treatment becomes a small number of successful completers. The Connecticut site's detailed documentation of the attrition and retention patterns in Project SAFE proved critical in taking Project SAFE to a new level of effectiveness. Once the agencies involved determined the volume of clients not showing up for appointments, client engagement, retention, and completion became much more important.

Many joint projects have no information on dropoff points. Very few State and local agencies have the information systems needed to track clients from the initial child abuse or neglect report through recovery. The Connecticut and Sacramento County sites' tracking systems are very good, but even these systems require periodic review to identify which new data to include on client status in substance abuse treatment and the child welfare system.

Some very expensive State and local systems are subsidized by Federal funds, but most cannot yet document the movement of clients across agency boundaries. The Statewide Automated Child Welfare Information System (SACWIS), which provides Federal oversight and funding for State child welfare information systems, has not addressed substance abuse issues in depth. According to the Federal guidelines disseminated in August 1998,

> The SACWIS should record on-going case work by the child welfare worker and child specific information to make a determination of reasonable efforts....The SACWIS should capture sufficient information to support a finding that the State has made reasonable efforts to reunite the family.[12]

Recently, this has been interpreted to mean that SACWIS capacity should include information on substance abuse. Federal guidelines suggest that SACWIS systems should be able to produce data on:

- The presence or absence of alcohol abuse by the parent as a factor in the child's foster care placement,
- The presence or absence of alcohol abuse by the parent as a factor in the parents' drug abuse,
- Child alcohol abuse, and
- Child drug abuse.

This may eventually lead to more useful reports from States on substance abuse in child welfare cases.

Evidence for the lack in some States of systematic information about substance-abusing parents in CWS is provided by California, which has more than one-fifth of all foster care cases in the Nation. In 1999, California reported to the Federal Adoption and Foster Care Analysis & Reporting Systems that 1.2 percent of its foster care caseload involved substance abuse. This number is clearly too low, as demonstrated by Oregon's figure of over 60 percent. Several other States have also found it difficult to accurately assess substance abuse for their Federal reports.

If most CWS cases involve substance abuse, it must be recorded in a way that can be recaptured later. The argument that substance abuse problems are just another factor in the case should not take precedence over the fact that substance abuse has a profound impact on the ultimate disposition of cases and the outcomes for the family and the child. In many federally funded State systems, entering data about substance abuse remains optional and many child welfare workers, already overburdened with complicated new systems, therefore do not record it.

Some of the sites place high priority on information systems and others recognize that they lack the data needed to determine whether their innovations are effective. Several sites know that information systems need to be addressed from the start of the initiative, rather than adding an evaluation component or information system after the program has been implemented.

Training and Staff Development

All the sites have undertaken new training initiatives. In several, especially Sacramento, it became clear that training by itself, without reinforcing policy changes, simply leaves front-line staff with more skills and, possibly, different attitudes, but without the incentives or supervision needed to use what they have learned. Without such policy incentives and leadership, the system reverts to the norm—single-system operations. A site proposing a training reform that has not developed policy incentives to institutionalize the reform may produce few permanent changes in the daily practice of front-line staff. Training reforms, like all of the 10 framework areas, are necessary but not sufficient to achieve lasting change in the connections among different systems. Once training reforms are reinforced through policy changes, they must be strengthened through booster sessions involving the staff of all participating agencies.

Budgeting and Program Sustainability

Excessive caseloads, such as those in Sacramento and Cuyahoga Counties, make workers wary for good reason. Some reforms initially appear to require more work with harder cases, less time, and the same level of resources. Judge Cohen in Miami observed that the services needed are so labor intensive that the system, as it is currently staffed, cannot respond adequately.

In a few sites, caseloads have been reduced as part of the reforms, so that both social workers and substance abuse treatment staff can respond to high-needs clients. Cuyahoga County's START program restricts caseloads to 15 for each social worker and family advocate team. While these models do not make clear how to replicate their low ratios across the entire caseload, they build the information base on better outcomes that are the only way, in the long run, to justify lower caseloads.

In some sites, caseload issues affect all child welfare and substance abuse treatment agencies and the courts. Some drug courts, in particular, have been hampered in their efforts to expand useful reforms by the judges' conviction that they must personally handle all cases as a kind of "super case manager." This has the obvious effect of restricting the innovation to only a few clients. The ability of judges to handle a caseload larger than that of a senior social worker or treatment case manager is limited, especially by their other court duties. Judges' ability to expand their innovations is, therefore, equally limited.

When some sites testify to the legislature about their caseloads, this may be perceived by legislators as motivated by self-interest. A sister agency can sometimes more effectively persuade legislators that staff workloads are affected by inadequate staffing in related agencies. Senior officials from treatment agencies speaking out on CWS caseloads have been more credible, site officials report, than CWS when it speaks for itself, and vice versa. New resources, especially TANF services funding, have been secured when the interagency approach includes not only client advocacy, but also interagency advocacy, to address the policy barriers to smaller caseloads.

Working with the Courts

Expanding dependency drug courts may be difficult if judges case manage clients, if only because the substance abuse treatment and CWS systems may lack the resources to replicate the drug courts' important achievements. Balance is needed between the court's power to compel treatment and the risks of allowing courts to reduce or blur the accountability of substance abuse treatment and CWS systems by assuming a direct case management role. In the abstract, the executive branch of government should have the tools and responsibility for producing results for their clients. But agencies are sometimes unable to deliver services in ways that judges regard as appropriate. Thus, some judges courageously intervene when they find that the gap between court orders and reality is too great to preserve the system's credibility.

In San Diego County, the system appears to be responding to dependency drug court pressures, although not yet with the full information resources needed to track client outcomes resulting from the actions of the dependency drug court over time. Whether the courts support or are barriers to systems change, their role is so vital that they are often a major force in enabling the CWS and substance abuse treatment agencies to work together, if only to present a more unified front to judges who want to know why the two agencies cannot agree about a client.

Dependency drug courts ask whether reform within substance abuse treatment and CWS agencies can ever produce the sense of urgency created by compulsory treatment that is backed up by guaranteed substance abuse treatment slots and close monitoring. By pointing out that many court orders to undergo substance abuse treatment are not taken seriously by the system because no timely treatment is available, drug courts simply but powerfully demand that the law be observed. They also underscore the fact that many judges ignore the law by failing to take action to link clients with treatment and monitor the effectiveness of treatment closely enough to determine which providers are most successful with referrals from the court.

The likelihood that dependency drug courts will change the system, rather than set up a separate track for a limited number of clients, depends on several prerequisites, as Judge Milliken and others have noted:

1. An expansion of treatment capacity;
2. An information system able to track clients into and through substance abuse treatment, determine treatment effectiveness across providers, and shift resources over time to the most effective providers and away from the least effective ones;
3. A close working relationship among courts, child welfare agencies, and substance abuse treatment agencies; and
4. Agreements on the kinds of information and consent procedures to improve the flow of client data for making final dispositions of cases.

All of these prerequisites are not always met in the two drug dependency courts reviewed and other emerging drug courts around the country.

Working with Related Agencies and the Community

Working with other agencies is an element of the framework that demands good information and good screening and assessment systems. Inadequate screening and assessment as clients enter the CWS system means that the need for supportive services often remains undetected. Although adding a substance abuse assessment tool to the CPS system is difficult, adding assessments for mental health, domestic violence, literacy, and other client problems is even more difficult. Yet several of the seven sites have done so and, as a result, have improved their ability to engage clients.

The community involvement sought in Jacksonville is a national model and represents the furthest extent seen of differential assessment, with community-based follow-up for less urgent cases.

Further Lessons: What to Tell Other Sites

Program leaders provided advice to sites that are beginning to design new ADS-CWS partnerships. Some of the common ingredients, in their own language, were:

- "Staff must be very, very versed in the language and psyche of addiction."
- "They must have strong knowledge of domestic violence issues."
- "[Staff need] good skills that can cross socioeconomic strata."
- "Be very, very, flexible."
- "Getting clients to be honest with you is a real art."
- "One of the most meaningful concepts was the idea of the four different clocks that are running."
- "Relapse is part of the disease. Child welfare needs to see that you can work beyond the relapse."
- "[Watch out for] We tell others how to change but 'don't make us change.'"

- "Persistence and tenacity. Don't wimp out on it. Keep at it. It took a while to get to the added values, but you couldn't take it away now."
- "Outstationed substance abuse specialists in each region—that added to the support we could get. The person on site has to be there to continue the work."
- "Make sure you have admission criteria. Know customer service. If you are going to work with a system as large and complicated as child welfare, learn their system."
- "The provider should include a multidisciplinary team."
- "Be sympathetic to the front-line person in the child welfare system."
- "Recruitment and retention in the addiction field is very difficult now. This can slow down start-up."
- "You must do follow-up as part of case management."
- "Make sure you have a strong front-end planning piece with all players involved these people have to come together-in depth."
- "You have to be prepared to deal with the hard issues."
- "Just because someone is a social worker does not mean they know chemical dependency treatment. Training must be provided."
- "The assessment piece needs a lot of discussion. All staff have to feel comfortable with the type of screening used."
- "The physical space has to be ample enough to do the job."

Summary: The Need for Balance

In addition to the 10 items in the framework used in this review, a sensitivity to the need for several kinds of *balance* contributed to the success of innovative reforms. A successful innovation does not try to accomplish everything, nor does it settle for only small steps forward. The leaders of the innovations studied understand that while progress is often incremental, they must keep in mind the longer term and the larger system into which the reform must fit. When leaders expanded their pilot projects, they did so with a clear plan for resources, supervisors' commitment, front-line training, and constituency building among providers, the community, legislators, and the courts.

The three areas in which balance is most important are: leadership, policy and practice, and marketing. These areas are discussed below.

The Importance of Leadership

In each of the sites reviewed, a leader from the child welfare, substance abuse treatment, or court systems stepped forward and showed other administrators and policymakers the concrete implications of reform. These leaders took action that involved risk, reaching beyond the status quo and standard procedures to new ways of doing things. All of the early reformers in the seven sites became champions for their reforms and were willing to defend them against the concerns of other, less farsighted stakeholders in the substance abuse treatment, CWS, and court systems.

An innovation without such leadership may remain merely an ineffective demonstration project, a well-intentioned effort that is unlikely to be sustained or demonstrate how to change the systems.

Finding true leadership is not simple, due to the powerful disincentives embedded in the culture and history of CWS and substance abuse treatment agencies. Reactive leadership is often the norm in State and local government, with the goal of staying out of the headlines. Innovation is not only risky in such settings, but violates the norms of organizational and political culture. For this reason, leadership in some of the settings reviewed consisted of seizing the opportunities created by a crisis—a tragic death, an investigation, or new data on program failures.

Leadership and collaboration are sometimes in apparent conflict, which can best be resolved by sharing credit. Working with other agencies in State and county government demands not only the ability to see the problem from the other agency's point of view, but the recognition that the other agency needs to collaborate seriously, rather than in a *pro forma* memorandum of agreement that essentially agrees merely to attend meetings. Leadership also demands empathy with other leaders; understanding that their legislative committees, constituents, or staff may not be as ready to change the old rules as the other agency in the partnership; and patience in waiting for consensus to develop at the other agency.

The art of leadership requires recognizing the differences in pace among collaborative partners, understanding what is causing the lag, and persevering in providing incentives for the other agencies to catch up.

In several sites, agency representatives said, off the record, that they felt at times that their agency had proceeded too far ahead of the partner agency and needed to develop joint working forums in which both groups could address the unresolved issues. In others, careful planning was said to be needed to prevent the less actively involved partner from feeling left out of a collaborative effort. Again, substance abuse treatment agencies, CWS agencies, and the courts rarely proceed at the same pace. The art of leadership requires recognizing the differences in momentum among collaborative partners, understanding what is causing the lag, and providing incentives for the other agencies to catch up.

Relationship development proved an equally important aspect of leadership. One agency leader explained, "Personal relationships and the willingness to stay with it were very important. It is not just changing systems, it is changing relationships that makes it happen." In some sites, leadership styles were more distant, formal, and authoritative, while in others, social events were planned across systems to ensure that both staffs got to know each other both in and outside of their working roles.

Active Balance Between Policy and Practice Changes

The most innovative sites do not draw a rigid line between practice and policy that is sometimes adopted by academic disciplines and practitioners. The best-grounded policy changes appear to be based on the demands and realities of daily practice, which is why 3 of the 10 elements in the framework focus on daily practice. At the same time, the most effective ADS-CWS partnerships show that innovations that remain focused only on practice have little chance of making the larger policy changes that truly change systems.

The San Diego site's experience suggests that, in contrast with some other dependency drug courts, the judge and his allies recognized the need to address systemwide changes, instead of simply forcing resources to be allocated from one group of clients to another. In Sacramento County, changes in practice that resulted from a greater shift in training approaches than in any other jurisdiction in the Nation had to be backed up with broader changes in policy—a move toward a systems of care treatment philosophy—before they were adopted agency wide. In Connecticut, data on the drop off points in substance abuse treatment became the basis for new policies and resources aimed at client engagement.

In each of these examples, policy and practice were fully complementary. Some practitioners dismiss policy discussions about the financial resources needed to expand programs because they regard budget issues as of limited relevance to the needs of real clients. However, some leaders argue that practice reforms are too marginal to affect the systems from which they emerge. Both miss the point, which is that the dialogue between practitioners and policymakers needs to be active, open, and continuing for each domain to gain full advantage of its links to the other. In the most effective sites, this dialogue is ongoing.

Marketing: The Panacea Problem

Balance is also critical in claims about an innovation's ability to solve problems. Many attempts to change systems are oversold at some point in their life cycles. Too often, a well-articulated policy change emerges, its proponents overstate its impact on a wide range of problems, and hard-pressed State and local leaders seize the innovation and raise expectations far beyond the innovation's original intent. Detractors then begin pointing out that the innovation will not solve all the problems of the current system, even though the innovation was never designed to do so.

All innovation is partial. Despite widespread use of the phrase "systems reform,"entire systems are rarely reformed all at once. CWS and substance abuse treatment agency leaders should not reject innovation that is only partial, because even if the innovation is designed to change only part of a "broken" system, it does respond to real problems. What is needed is deliberate use of a protocol for innovation—a set of questions about how innovations will affect the larger systems. This protocol for innovation might include the following questions that were suggested by the site reviews and other innovations that have sometimes failed to address these issues, to their detriment:

- How are children affected—what is their role in the innovation? What services will be provided for them while their parents are in treatment?
- Which clients does the innovation target and how do they compare to other clients? Is the innovation only effective for clients who are easier to serve? What implications does this have for the rest of the caseload?
- Which clients are most likely to have motivation problems and which client engagement approaches will be used to address these problems? How will client-monitoring systems track clients at the key drop off points? Which information systems and client databases are required to document these client characteristics and responses to services?
- If resources are shifted to this innovation, what effects will that shift have on the rest of the system? How will those agencies and staff members whose resources are shifted react?
- How can the innovation be sustained, replicated, and expanded? If the innovation is effective for a pilot group of clients, how will its benefits be extended to other clients? How will institutionalized funding streams be tapped to build on the temporary pilot funding?
- What new skills will be required for front-line workers to support the innovation? Have adequate staff development resources been set aside to provide those skills?
- Will the courts agree with the interpretation of clients' problems that is reflected in this innovation?

These questions anticipate some of the inevitable roadblocks that accompany implementation. They might even be written into requests for proposals or funding guidelines by public or private agencies to ensure that the planning for an ADS-CWS project proposal addresses how the sponsors will deal with these issues before the project begins.

The Stakes for Substance Abuse Agencies

Finally, a set of questions that have come up repeatedly in working with treatment agencies needs to be answered:

- Why should substance abuse treatment funders and providers give children and families in the child welfare system more priority than other clients?
- What knowledge does the substance abuse treatment system have based on its prior work with parents and children?
- What is the effect of the growing pressure for accountability in serving substance-abusing clients on services for parents and children?
- What other materials and resources are available to address directly the needs of parents and children with substance abuse problems?

Although the answers to these questions are assumed to be positive in this report, substance abuse treatment agencies are under pressures and demands for resources that raise questions about resource allocation among the different groups. The good news is that a growing number of agencies outside the alcohol and drug treatment field have come to recognize that substance abuse treatment does work, and are seeking additional treatment resources for clients of the criminal justice system, the juvenile justice system, mental health systems, vocational agencies, and others. But Substance Abuse Prevention and Treatment Block Grant (SAPTBG) resources are stretched too thinly to cover these growing requests—which are actually demands, in the case of the court systems—for added treatment assessment, slots, and services.

The reality of limited resources helps to answer some of the above questions, because substance abuse treatment agencies need to cooperate more actively with agencies that serve children and families in order to command additional resources from those agencies. Spreading the SAPTBG across more groups will not improve program impact or effectiveness. But abundant evidence exists from the most active ADS-CWS sites that such partnerships can mobilize resources for substance abuse treatment clients that agencies cannot obtain on their own, including Medicaid, TANF, and child welfare funds.

Substance abuse treatment agencies have gained valuable experience over the past decade in several federally and State-funded demonstration projects, including the 33 residential treatment projects for substance-abusing pregnant and postpartum women and their children funded by CSAT in the early 1990s. The most effective of these secured several other funding sources for their work, which is both a credit to their skill in resource mobilization and a painful reminder of the workings of the categorical funding system.

Substance abuse treatment agencies also have a programmatic track record in successful treatment and recovery for a considerable percentage of women in these programs. These services appear to have a cumulative impact on reducing risks for infants, including death, preterm delivery, and low birth weight.[13] CSAT has published several monographs and treatment improvement protocols that delineate components of comprehensive treatment programs for women and their children.[14]

Why substance abuse treatment agencies should serve children and parents can also be answered by noting that comprehensive substance abuse treatment focused on parents and children is an extremely effective way of preventing further treatment problems among COSAs. The growing literature on COSA-targeted programs makes clear that a variety of successful approaches can be adapted by substance abuse treatment agencies. As some of the substance abuse treatment agencies in the case studies demonstrate, services for parents without services for their children ignore the family origins of substance abuse problems.

Three major changes seem likely to affect substance abuse treatment agencies' need to work more actively with parents and children:

1. The TANF and ASFA time limits resulting from the demand for better, faster results and the implementation of the information systems needed to determine whether those results are being achieved;
2. The TOPPS[15] process, as it strengthens States' and providers' capacity to monitor the outcomes of treatment more effectively; and
3. Child welfare services reviews, including monitoring changes in child welfare outcomes that require a broader assessment and monitoring of children's services.

Each represents a move toward more results-based accountability. Taken together, they add considerable weight to the efforts of leading providers and some States to hold substance abuse treatment agencies accountable for services to both parents and their children.

Conclusion

Three alternative scenarios can be predicted for substance abuse treatment agencies vis-a-vis children and families. In the first, most pessimistic scenario, child welfare, welfare, and juvenile justice agencies continue to move toward funding substance abuse treatment programs whose staff members are directly under the control of the non-treatment agency to ensure priority treatment services for its own clients. Some child welfare practitioners refer to this as the "buy our own" strategy. Ample evidence already exists of child welfare agencies pursuing this approach at both State and county levels. This pattern is also evident in some of the sites studied for this report, most notably in the early implementation in Connecticut and New Jersey. In some States, this trend is compounded by a parallel trend in criminal justice and corrections agencies that purchase their own substance abuse treatment services directly from providers and bypass the substance abuse treatment agency.

If a child welfare, TANF, or corrections agency is under pressure to respond more effectively to the substance abuse treatment needs of its clients, it is reasonable in the short run to purchase treatment services from local agencies. But the results for substance abuse treatment agencies are obvious:

- Quality control becomes more difficult;
- Standards of care cannot be supervised in agencies outside the substance abuse treatment structure;
- Different rates of reimbursement by different funders may make providers less inclined to serve the State substance abuse treatment agencies' clients if they are reimbursed at lower rates;
- Statewide information systems may not include a growing number of substance abuse treatment episodes and outcomes outside of the publicly funded system; and
- Substance abuse treatment agencies are relegated to their current customer mix with opportunities for expansion limited to adult caseloads without children—a

sizable market, but one that may have built-in limits in growth and future funding prospects.

In the second, more optimistic scenario, substance abuse treatment agencies are active partners of agencies serving children, youth, and families. In this scenario, substance abuse treatment funding consists of resources far greater than the SAPTBG, which can then be used in combination with a wide array of public and private funds for a more diverse set of clients. Nearly equal numbers of men and women are enrolled in substance abuse treatment, and services to COSAs are funded by a variety of non-block-grant sources. Standards of care and shared assessment tools are used to monitor the results of substance abuse treatment in a way that improves quality of care for all alcohol and drug prevention and treatment clients. Most importantly, agencies that face the choice of buying their own services or working through State and local substance abuse treatment agencies gain enough confidence in the quality of services channeled through substance abuse treatment agencies to prefer to contract through the treatment agency, rather than an independent provider.

Trends toward both these scenarios are visible today. But leadership from State and local substance abuse treatment agencies will be needed to make the second scenario happen at scale. Retaining and, when necessary, restoring the credibility of substance abuse treatment oversight agencies at State and local levels will require systemic strategies that go beyond pilot projects. The hopeful news is that the best of the sites studied for this report demonstrate this kind of leadership capacity as they work with their child welfare counterparts, the courts, and other agencies. They show that substance abuse treatment oversight agencies have a better chance to provide accountability for results through investments in information systems and indepth monitoring of clients progress. They have tapped new funding sources, notably TANF, and have reduced their reliance on a single categorical block grant for funding categorical programs.

Thus, plenty of evidence exists for the feasibility of the more optimistic scenario. Timing is still a challenge, however, as the fifth clock, which measures the time required for agency staff to respond to the demands imposed by the other four clocks, never stops running, and thousands of new clients are affected by time limits or enter the system for the first time every day. Time is running out for clients and the systems that are trying to serve them, and the tools to work together more effectively are not yet available as widely as they need to be.

In a third possible scenario, the public and elected officials lose patience with all three of the major partners—CWS, substance abuse treatment agencies, and the courts—and mandate drastic new actions in States where substance abuse treatment failure is defined more and more narrowly. Patience could also be lost due to confidentiality disagreements, stripping both CWS and substance abuse treatment clients of their right to privacy based on child safety and public efficiency. New legal attacks on reasonable efforts required to reunify families, based on a lack of compliance with ASFA's time limits and services provided during those time limits, are a further unpredictable force that could accelerate the loss of credibility of incremental efforts to link child welfare and substance abuse treatment systems.

Without a new sense of urgency, the CWS and substance abuse treatment systems and their partners in the courts may find themselves passively waiting for one or more of these scenarios to happen, hoping it will be a positive one. The strength of the seven sites reviewed for this report and the lessons learned from their efforts and those of other sites around the Nation show the feasibility of reform. But without leadership, the feasibility of reform is just a hypothetical possibility. With leadership that seeks the resources to move quickly—more quickly than most State and local child welfare and treatment agencies have moved to date—the possible will become more probable.

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20. How many children do you have, aged 17 or less (birth or adopted)—whether they live with you or not?
21. If you have children aged 17 or less (birth or adopted), how many of these children spent the majority of the past living with you (30 days; 6 months)?
22. Living with someone else because of a child protection court order (child protection court, not divorce court)? If you have children living with someone else because of a child protection order, for how many of these children have you parental rights been terminated (30 days; 6 months)?

APPENDICES

Appendix I-A:
Collaborative Capacity Instrument

COLLABORATIVE CAPACITY INSTRUMENT
FOR REVIEWING ASSESSING THE STATUS OF LINKAGES ACROSS
ALCOHOL AND DRUG TREATMENT AND CHILD WELFARE SERVICES

This tool is intended to be used as a self-assessment by County (and/or State) alcohol and other drug (AOD) service and child welfare service (CWS) agencies who are preparing to work with each other or who may be seeking to move to a new level of cooperation after some initial efforts. The questions have been designed to elicit discussion among and within both sets of agencies about their readiness for closer work with each other.

Name of County/State: ___________________________

I work in: (circle one) AOD   CWS   Dependency Court   Other

I work as: (circle one)   Supervisor   Manager   Administrator   Other

Circle the response category that most closely represents your extent of agreement with each of the following statements:

Underlying Values and Principles of Collaborative Relationships

1. Our county CWS and AOD agencies have begun discussions about their differences in underlying values and principles.

   Agree   Somewhat Agree   Disagree   Not Sure

2. Our county AOD and CWS agencies have used a formal values assessment process to determine how much consensus or disagreement we have about issues related to AOD use, parenting, and child safety.

   Agree   Somewhat Agree   Disagree   Not Sure

3. Our county AOD and CWS agencies have negotiated a shared principles or goal statement that reflects a consensus of the two agencies.

   Agree   Somewhat Agree   Disagree   Not Sure

4. Our county has prioritized parents in the CWS system for AOD treatment services.

   Agree   Somewhat Agree   Disagree   Not Sure

5. Our county has developed strategies to recruit broad community participation in addressing the needs of AOD-CWS-involved families.

Agree Somewhat Agree Disagree Not Sure

6. Our county's dependency court system has realistic expectations for CWS parents with AOD problems (e.g., approach to relapse and zero tolerance issues).

Agree Somewhat Agree Disagree Not Sure

7. In our county, CWS staff and the courts view alcohol abuse as much as a major risk factor as they do other drugs for child abuse and/or neglect.

Agree Somewhat Agree Disagree Not Sure

8. Our county has discussed and developed responses to the conflicting time frames associated with CWS, CalWORKs, AOD treatment and child development.

Agree Somewhat Agree Disagree Not Sure

Daily Practice–Client Intake, Screening, and Assessment

1. Our county has successfully out-stationed AOD workers at CPS offices to help with screening and assessment of clients.

Agree Somewhat Agree Disagree Not Sure

2. Our county has multi-disciplinary service teams that include both AOD and CWS workers

Agree Somewhat Agree Disagree Not Sure

3. Our county has developed coordinated AOD treatment and CPS case plans.

Agree Somewhat Agree Disagree Not Sure

4. In our county CWS staff supplement child abuse/neglect risk assessment with an in-depth assessment of AOD issues and their impact on the family.

Agree Somewhat Agree Disagree Not Sure

5. Our county's CWS intake process is able to identify prior AOD treatment episodes based on previously negotiated information sharing protocols.

Agree Somewhat Agree Disagree Not Sure

6. Our county's AOD intake process identifies clients who are involved in the CWS system based on previously negotiated information sharing protocols.

   Agree Somewhat Agree Disagree Not Sure

7. Our county documents AOD factors by consistently using the optional data fields in the CWS/CMS data system.

   Agree Somewhat Agree Disagree Not Sure

8. When our AOD treatment providers assess clients, they routinely include questions about children in the family, their living arrangements, and CWS involvement.

   Agree Somewhat Agree Disagree Not Sure

Daily Practice–Client Engagement and Retention in Care

1. Our county's CWS staff have the skills and knowledge to talk with their clients about their AOD use and related problems.

   Agree Somewhat Agree Disagree Not Sure

2. Our county's AOD staff have the skills and knowledge to talk with their clients about child safety and CWS involvement.

   Agree Somewhat Agree Disagree Not Sure

3. Our county CWS staff provide outreach to clients who do not keep their initial AOD appointments or drop out of treatment.

   Agree Somewhat Agree Disagree Not Sure

4. Our county AOD staff track the status of their clients progress in the CWS system.

   Agree Somewhat Agree Disagree Not Sure

5. Our agency has developed and trained our staff in approaches to our clients which ensure that clients are more likely to stay in treatment once they enter it.

   Agree Somewhat Agree Disagree Not Sure

6. In our county, CWS and AOD agencies have agreed on the level of information about clients' progress in treatment which will be communicated from treatment agencies to CWS workers and the courts.

   Agree Somewhat Agree Disagree Not Sure

7. In our county, client relapse typically leads to a collaborative intervention to re-engage the client in treatment and to re-assess child safety.

   Agree Somewhat Agree Disagree Not Sure

8. In our county, drug testing is used in combination with a treatment program to monitor clients' compliance with treatment plans.

   Agree Somewhat Agree Disagree Not Sure

9. Rate your county's AOD treatment on the following areas:

	Poor		Fair		Excellent
Gender specific	1	2	3	4	5
Culturally relevant	1	2	3	4	5
Geographically accessible	1	2	3	4	5
Family focused	1	2	3	4	5
Child-specific	1	2	3	4	5
Adolescent treatment	1	2	3	4	5

Daily Practice - Services to Children

1. Our county has implemented substance abuse prevention and early intervention services for children in the CWS system.

   Agree Somewhat Agree Disagree Not Sure

2. Our county's Independent Living Program includes significant content on the impact of AOD use.

   Agree Somewhat Agree Disagree Not Sure

3. Our county has developed a range of programs for children of substance-abusing parents that are targeted on the special needs of these children.

   Agree Somewhat Agree Disagree Not Sure

Joint Accountability and Shared Outcomes

1. Our county's AOD agency has identified system outcomes and have communicated them to the CWS.

   Agree   Somewhat Agree   Disagree   Not Sure

2. Our county's CWS agency has identified system outcomes and have communicated them to the AOD agency.

   Agree   Somewhat Agree   Disagree   Not Sure

3. Our county AOD and CWS agencies and the courts have developed shared outcomes for CWS-AOD involved families and have agreed to use this information to inform policy leaders.

   Agree   Somewhat Agree   Disagree   Not Sure

4. Our county has developed outcome criteria in their contracts with community-based providers (who serve CWS-AOD clients) to measure their effectiveness in achieving shared outcomes.

   Agree   Somewhat Agree   Disagree   Not Sure

5. Our county has shifted funding from providers who are less effective in serving clients in the both CWS-AOD systems to those that are more effective.

   Agree   Somewhat Agree   Disagree   Not Sure

6. In our county, CWS-AOD involved parents are referred to parenting programs that have demonstrated positive results with this population.

   Agree   Somewhat Agree   Disagree   Not Sure

7. Our county CWS agency shares accountability with their AOD counterpart for successful treatment outcomes for their mutual clients.

   Agree   Somewhat Agree   Disagree   Not Sure

8. Our county AOD agency shares accountability for positive child safety outcomes for clients who have enrolled in treatment programs.

   Agree   Somewhat Agree   Disagree   Not Sure

9. In our county, drug testing is used in the court system as the most important indicator of clients' success in resolving their AOD problem.

Agree Somewhat Agree Disagree Not Sure

Information Sharing and Data Systems

1. Our county has identified the confidentiality provisions that affect CWS-AOD connections and has devised means of sharing information while observing these regulations.

Agree Somewhat Agree Disagree Not Sure

2. Our county consistently uses the CWS/CMS field on AOD factors related to the case.

Agree Somewhat Agree Disagree Not Sure

3. Our county AOD services have supplemented the alcohol/drug data system (CADDS) to generate data on their clients children and their CPS involvement.

Agree Somewhat Agree Disagree Not Sure

4. Our county has developed the capacity to automate data about the characteristics and service outcomes of the clients who are in both the CWS and AOD caseloads.

Agree Somewhat Agree Disagree Not Sure

5. Our county has initiated efforts and/or has the capacity to track CWS/AOD clients across information systems.

Agree Somewhat Agree Disagree Not Sure

Training and Staff Development

1. Our county CWS ensures that all managers, supervisors and workers receive training on working with AOD-affected families.

Agree Somewhat Agree Disagree Not Sure

2. Our county AOD agency ensures that their staff/providers receive training on working with families in the CWS system.

Agree Somewhat Agree Disagree Not Sure

3. Our county has developed joint training programs for AOD-CWS staff and providers to learn effective methods of working together.

   Agree   Somewhat Agree   Disagree   Not Sure

4. Our county has a multi-year staff development plan that includes periodic updates to the training and orientation received by the staff of both CWS and AOD agencies.

   Agree   Somewhat Agree   Disagree   Not Sure

5. Our county has training programs that include cultural issues to improve their cultural relevance and competency in working with diverse AOD-CWS client groups.

   Agree   Somewhat Agree   Disagree   Not Sure

Budgeting and Program Sustainability

1. Our county CWS agency currently uses a portion of its funding for AOD treatment services (excluding drug testing).

   Agree   Somewhat Agree   Disagree   Not Sure

2. Our AOD treatment agencies currently use a portion of their funding for services to improve clients' parenting skills.

   Agree   Somewhat Agree   Disagree   Not Sure

3. Our County uses a portion of its CalWORKs allocations to fund programs for AOD-CWS clients.

   Agree   Somewhat Agree   Disagree   Not Sure

4. Our county's CWS and AOD agencies have jointly sought funding for pilot projects to work more closely together.

   Agree   Somewhat Agree   Disagree   Not Sure

5. Our county has identified the full range of potential funding from all sources that could support the changes needed to work more closely across CWS-AOD agencies.

   Agree   Somewhat Agree   Disagree   Not Sure

6. Our county has identified the waivers that would be needed to fully utilize available funds for families in the CWS-AOD systems.

   Agree Somewhat Agree Disagree Not Sure

7. Our county has a multi-year budget plan to support integrated CWS-AOD services.

   Agree Somewhat Agree Disagree Not Sure

Working with the Courts

1. Our county has included the dependency court personnel as equal partners in the development of new approaches to providing treatment services to parents in the child welfare system.

   Agree Somewhat Agree Disagree Not Sure

2. Our county has developed formal working agreements with the courts that include how child welfare and treatment agencies will share information about clients in treatment with the court system.

   Agree Somewhat Agree Disagree Not Sure

3. Our county's dependency court system has adequate access to treatment monitoring information to determine how parents are progressing through treatment in a timely way.

4. Our county has included the dependency court personnel as equal partners in the development of new approaches to providing treatment services to parents in the child welfare system.

   Agree Somewhat Agree Disagree Not Sure

5. Our county has trained court staff in the approaches to substance abuse treatment which are most effective.

   Agree Somewhat Agree Disagree Not Sure

Working with Related Agencies

1. Our county CWS staff know how to identify and link families with the other services that are frequently needed by CWS-AOD involved clients (e.g., transportation, child care, family violence services, mental health services) and makes referrals to those agencies.

   Agree Somewhat Agree Disagree Not Sure

2. Our county AOD staff/providers know how to identify and link CWS-involved families with the other services that are frequently needed services (e.g., transportation, child care, family violence services, mental health services) and make referrals to those agencies.

   Agree Somewhat Agree Disagree Not Sure

3. Our county's parent education programs used by CWS clients include significant content on the impact of AOD use on family functioning and parenting.

   Agree Somewhat Agree Disagree Not Sure

4. Our county has AOD support/recovery groups that include a special focus on CWS and child safety issues.

   Agree Somewhat Agree Disagree Not Sure

5. Our county coordinates with law enforcement, AOD, and CWS to meet the needs of parents and their children affected by the criminal justice system (e.g., visitation for children with incarcerated parents, treatment while parents are incarcerated).

   Agree Somewhat Agree Disagree Not Sure

Appendix IV-A:
Connecticut Screening Tool

DCF-2110
11/98 (Revised)
File: Medical

State of Connecticut
Department of Children and Families

SUBSTANCE ABUSE SCREENING / INFORMATION FORM

Date: ____/____/________
DCF Worker: ______________________ Phone: ______________
DCF Supervisor: ______________________ Phone: ______________
Client Name: ______________________ SAFE #: ______________
Date client referred to SAFE, if applicable: ______________________

This form shall be completed by the social worker upon return to the office. Please check every box either "yes" or "no", as appropriate. If there is any "yes" box checked for questions 1-13, a referral for an evaluation shall be made to Project Safe.

1. Yes ☐ No ☐ Client appeared to be under the influence of drugs and/or alcohol.
2. Yes ☐ No ☐ Client showed physical symptoms of trembling, sweating, stomach cramps, nervousness.
3. Yes ☐ No ☐ Drug paraphernalia was present in the home, i.e., pipes, charred spoons, foils, blunts, etc.
4. Yes ☐ No ☐ Evidence of alcohol abuse was present in the home, i.e., excessive number of visible bottles/cans whether empty or not.
5. Yes ☐ No ☐ There was a report of a positive drug screen at birth for mother ☐, child ☐; list drugs detected: ______________________
6. Yes ☐ No ☐ There was an allegation of substance abuse in the CPS report.
7. Yes ☐ No ☐ The child(ren) reports substance abuse in the home. When? ______________
8. Yes ☐ No ☐ The client has been in substance abuse treatment. When? ______________
9. Yes ☐ No ☐ The client has used the following in the last twelve months: ☐ Marijuana/Hashish; ☐Heroin/Opiates; ☐Cocaine/Crack; ☐Other drugs: ______________
10. Yes ☐ No ☐ Client shared that s/he has experienced negative consequences from the misuse of alcohol, i.e., ☐ DWI/DUI; ☐ Domestic Fights; ☐ Job Loss; ☐ Arrests; ☐ Other: ______________________
11. Yes ☐ No ☐ Client shared s/he has experienced trouble with the law due to the use of alcohol or other drugs, i.e., ☐ DWI/DUI; ☐ Domestic Violence; ☐ Drug Possession Charge; ☐ Other: ______________________
12. Yes ☐ No ☐ There are adults who may be using drugs and/or misusing alcohol who have regular contact with the client's child(ren).
13. Yes ☐ No ☐ The client acknowledged medical complications due to the use of substances.
14. Other comments: ____

Please fax this form and completed "Substance Abuse-Authorization For Release Of Information -" (DCF-2133) to the designated Project Safe Provider. Consult your substance abuse specialist as needed.

Appendix IV-B:
Connecticut Guideposts of Project SAFE Phase II

CONNECTICUT PROJECT SAFE

Guideposts for the Development of Phase II

1. There is an expectation that referrals to Project SAFE will increase due to the requirements of the Adoption and Safe Families Act of 1997, the increased experience and satisfaction of DCF workers with Project SAFE, and a variety of other factors.

2. There is a commitment to introduce new approaches to continue improvements in the slow rate for evaluations as well as for treatment retention and completion.

3. There is a desire to consider the inclusion of prevention, intervention and related services for the children of the referred adults, or to at least enhance the family model of the service.

4. There is a shared resolution to focus on the delivery and funding of services clearly demonstrated to yield good case finding, initial engagement and continued participation in treatment, and successful discharge outcomes for the clients.

5. There is an awareness that the proposed case management services will need to be far greater than proposed, given the expected increase in case findings as well as the intended purpose of the case management.

6. There is a recognition that referred cases need to be assessed for their treatment needs, for the degree of risk relative to DCF criteria, and for readiness for the recommended treatment.

7. There is a consensus that a strong linkage is needed between DCF workers and treatment providers for individual treatment planning and monitoring purposes, yet to a degree that would be very difficult for the DCF workers to meet, given the demands on their time.

8. There is a decision to focus on the clinical and support services needs of the referred clients, so that the design of the outpatient and potential residential services reflects those needs, and will strictly monitor expected outcomes.

9. There is a desire to assess how the proposed assumption of treatment design and costs coincide with recommendations of the Connecticut Alcohol and Drug Policy Council regarding client-based models for women and children and for youth and families, the goals of a full capacity system, and any unknown changes in DMHAS funding.

10. There is an intent to include training and related options through DMHAS's contract with the Connecticut Consortium for Women and Their Children with Behavioral Health Needs. There are collaborative contracting possibilities produced from the technical assistance (TA) initiative being supported by the federal Center for Substance Abuse Treatment (CSAT), and other TA relevant to the latest and best clinical practices.

12. There is a need to explore other funding options beyond the fee for services format currently in effect in order to better fit the treatment needs of the various levels of target cases and to reinforce providers for good outcomes.

13. There is agreement on the goal of assuring that all possible federal and specialty funding sources are reviewed for the applicability to the intended services, e.g., IV-E, TANF, SA Block Grant, Welfare to Work, and Medicaid.

14. There is a necessity of determining whether there are any instances in which a service provider is having difficulty achieving minimum standards for service utilization under the DMHAS contract and, thus, the reimbursement for DCF for immediate access could be questionable.

15. There is a commitment to identify the source, format and volume of funding mechanisms for Project SAFE services after the requirements associated with the above areas are met.

Appendix V-A:
New Jersey Substance Abuse Referral Form

Effective 6-11-99
Replaces New

DYFS Form 11-46, Substance Abuse Assessment Referral Form

PURPOSE AND USE

The form is used by the DYFS Case Manager to refer a DYFS client for a complete substance abuse assessment to determine:

- if the client has a substance abuse problem,
- the level of severity of the substance abuse problem and
- the level of care the client requires to appropriately treat the substance abuse problem.

The referral is made when:

- a referral alleges a child may be at risk of abuse/neglect due to the presence of substance abuse in the home;
- the observations of the Case Manager in an ongoing case indicates substance abuse poses a risk of child abuse or neglect; or
- family reunification of a child in out-of-home placement may be delayed or not occur due to the substance abuse of the parent/caretaker.

INSTRUCTIONS FOR COMPLETING THE FORM

District/ARC Office/Date Referred:	Enter the name of the DYFS District/ ARC Office making the referral and the date of the referral.
Case Name/KC #:	Enter the name of the case as registered on SIS and the assigned KC number.
Case Manager/Phone #:	Enter the name of the assigned Case Manager and his/her direct telephone number, including area code.
Supervisor/Phone #:	Enter the name of the supervisor of the assigned Case Manager and his/her direct telephone number, including area code.

Litigation Case:	Circle 'yes' or 'no' to indicate if the case is in litigation, i.e., termination of parental rights.
TANF/GA Eligible:	Circle 'yes' or 'no' to indicate verification of client's eligiblity for Temporary Assistance to Needy Families (TANF)/General Assistance (GA) benefits.
Mother:	Enter the name, address and telephone number of the mother of the child(ren) under supervision in the case.
Father:	Enter the name, address and telephone number, if known, of the father of the child(ren) under supervision in the case.
Child(ren's) Name(s)/Age:	List the full name(s) and age(s) of the child(ren) of the suspected substance abuser for whom the referral is being made.
In-Home/Out-of-Home:	Enter a check mark in the appropriate box next to each child's name to indicate the child's placement status at time of referral.
Suspected Drug or Alcohol User:	Enter the full name, address, social security number (optional), and date of birth (DOB) of the person suspected of using drugs and/or alcohol.
Health Insurance/ Medicaid Provider & Identification Number:	Enter the suspected user's health insurance/Medicaid provider and insurance identification number, if known.
Type(s)Substance(s):	List the names of the substance(s) the referred person is alleged or reported to use.
Duration of Reported Use:	Enter the amount of time, i. e., months, years, the referred person indicates he/she has been using the alleged substances.
Cooperation Level:	Circle the appropriate term to describe how willing the referred person is to entering treatment.
Priority Level for Referral:	Circle one of the three listed priority levels which

best describes the type of case being referred.
Note: Completed by DYFS Gatekeeper.

Comments: Enter any pertinent substance abuse case information that may be helpful to the in-house CADC or the community-based substance abuse provider in conducting the substance abuse assessment.

PROCESSING THE FORM AND SIGNATURES

DYFS Case Manager/Date: The assigned DYFS Case Manager signs and dates the form and forwards it to his/her supervisor.

DYFS Case Supervisor/Date: The assigned DYFS Case Supervisor reviews, signs and dates the form and forwards it to the DYFS Gatekeeper/Liaison OR

[For Cases in Transition…] The DYFS assigned Unit Supervisor, if known, or Casework Supervisor reviews, signs and dates the form for any case that does not have an assigned Case Manager and forwards it to the DYFS Gatekeeper/ Liaison.

DYFS Gatekeeper/Liaison: The DYFS District/ARC Office staff member assigned as the liaison between the staff and the in-house CADC, circles the priority level, signs and dates the form, and forwards it to the in-house CADC or community-based substance abuse provider.

Substance Abuse Counselor: The in-house CADC or community-based substance abuse provider signs and dates the form upon receipt and sends a copy to the DYFS Case Manager for the case record.

DISTRIBUTION

Original - In-house CADC or Community-based Substance Abuse Treatment Provider

Copy - DYFS Case Record

DYFS 11-46
Rev. 4-7-2000

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
Division of Youth and Family Services

Substance Abuse Assessment Referral Form

District/ARC Office(name/address)/Date Referred:____________________

Case Name: ____________________ KC #:__________

Case Manager/Phone #:____________________

Supervisor/Phone #:____________________

Litigation Case (circle one): Yes No TANF/GA Eligible (circle one): Yes No

Mother(name, address, phone #):____________________

Father(if known, name, address, phone #)____________________

Child(ren')s Name(s)/Age	In-Home or Out-of-Home(check✓)	
1.____________________	☐	☐
2.____________________	☐	☐
3.____________________	☐	☐
4.____________________	☐	☐

Suspected Drug Or Alcohol User:

Name: ____________________ SS# (Optional):__________

Address: ____________________ DOB:__________

Health Insurance/Medicaid Provider & Identification Number (If known): __________

Type(s) Substance(s)Reported/Suspected of Use____________________

Duration of Reported Use:____________________

DYFS 11-46
Rev. 4-7-2000

Cooperation Level re: Treatment (circle one): Poor Fair Good

Priority Level for Referral (DYFS Gatekeeper circles one):

Priority #1: Cases that are referred, either at intake or during an on-going case, in which it is believed that substance abuse within the home poses an imminent risk of harm to the child for abuse or neglect.

Priority #2: Existing DYFS in-home supervision cases in which substance abuse poses a risk of harm to the child for abuse or neglect.

Priority #3: Out-of-home placement cases in which family reunification may be delayed or cannot occur due to substance abuse of the parent/caretaker.

Comments (Relevant to suspected substance abuse.):

____

____

____

____

SIGNATURES

DYFS Case Manager______________________ Date__________

DYFS Case Supervisor______________________ Date__________

[For cases in transition, i.e., from intake to ongoing supervision, from unit to unit, from worker to worker: DYFS Assigned Unit Supervisor/Casework Supervisor]

______________________ Date__________

DYFS Gatekeeper/Liaison______________________ Date__________

Substance Abuse Counselor______________________ Date Rec'd.________

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REFUSAL FOR TREATMENT

Client's Name: ________________________________ **KC#:** ____________________

I, ______________________________ refuse to participate in the Child Protection Substance Abuse
(Print Name)

Initiative assessment and understand that this refusal will become part of my DYFS case file.

I, refuse to accept the referral to ____

given to me by ____

____________________________ ☐ Client refused to sign
(Client's Signature and Date)

____
(Substance Abuse Counselor and Date)

____
(DYFS Caseworker and Date)

CONSENT FOR DISCLOSURE OF RECORDS

(ALL APPROPRIATE BLANKS MUST BE FILLED IN)

I, ______________________________ hereby authorize ______________________________

to disclose/ to request from

____

(Specify individual, agency or organization and address)

for the purpose of ____

the following information regarding ______________________________________
(Client Name)

Date(s) of Treatment ____

D.O.B. __________________________ Social Security No. __________________

CHECK ONLY THOSE WHICH APPLY:

PROCESS FOR RELEASE __________________ VERBAL ______________________

WRITTEN ______________________ _____ OTHER (SPECIFY) ______________

___ INTAKE ASSESSMENT

___ PSYCHIATRIC ASSESSMENT

___ PHYSICAL HEALTH ASSESSMENT

_____ PSYCHOLOGICAL ASSESS/TESTING

_____ DRUG/ALCOHOL INFORMATION

_____ INTER AGENCY COMMUNICATION

___ OTHER (PLEASE SPECIFY) ____

This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked this consent will terminate 90 days from the date of signature.

Date _______________ Signature ______________________________________
Client

Date _______________ Signature ______________________________________
Legal Guardian (if applicable)

Date _______________ Witness ______________________________________

NOTE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2.) The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse consumers.

CHILD PROTECTION

SUBSTANCE ABUSE INITITATIVE

CLIENT RIGHTS

1. YOU HAVE THE RIGHT TO SERVICES PROVIDED BY THE DYFS CPSAI WITHOUT REGARD TO RACE, RELIGION, SEX, ETHNIC BACKGROUND, AGE, SEXUAL ORIENTATION, PHYSICAL DISABILITY, EMPLOYMENT STATUS, INSURANCE COVERAGE, OR ANY OTHER NON-CLINICAL REASON.

2. YOU HAVE THE RIGHT TO BE INFORMED ABOUT ALL PROGRAM POLICIES WHICH AFFECT ANY SERVICES YOU RECEIVE.

3. YOU HAVE THE RIGHT TO PROFESSIONAL, COMMITTED AND QUALIFIED SERVICES.

4. YOU HAVE THE RIGHT TO PARTICIPATE WITH YOUR COUNSELOR IN ESTABLISHING YOUR SERVICE GOALS.

5. YOU HAVE THE RIGHT TO BE TREATED WITH DIGNITY AND RESPECT.

6. YOU HAVE THE RIGHT TO QUESTION ANY ASPECT OF YOUR SERVICES PROVIDED BY THE CPSAI PROVIDER.

7. YOU HAVE THE RIGHT TO REVIEW YOUR FILE. THE REVIEW MUST BE BY PREARRANGED SCHEDULE.

MY RIGHTS HAVE BEEN CLEARLY READ AND EXPLAINED TO ME. I HAVE BEEN GIVEN A COPY FOR MY OWN USE. MY SIGNATURE BELOW IS AN ACKNOWLEDGEMENT THAT I UNDERSTAND MY RIGHTS.

CLIENT SIGNATURE	DATE
SUBSTANCE ABUSE COUNSELOR SIGNATURE	DATE

CHILD PROTECTION

SUBSTANCE ABUSE INITITATIVE

RELEASE OF INFORMATION FOR EMERGENCY PURPOSES

In the event of an emergency, I ______________________________, hereby give DYFS, Child Protection Substance Abuse Initiative permission to release the following information to emergency medical personnel.

CHECK ONLY THOSE WHICH APPLY:

PROCESS FOR RELEASE: _____ VERBAL_____ WRITTEN _____

OTHER (SPECIFY) __________

_____ Current medications

_____ Physical health status

_____ Mental health status

_____ History of surgeries/procedures

_____ Insurance coverage

______________________________ ______________________________

Client Signature Date

______________________________ ______________________________

Legal Guardian (If Applicable) Date

______________________________ ______________________________

Witness Signature Date

Appendix V-B:
Triage Assessment for Addictive Disorders

TAAD

Triage Assessment for Addictive Disorders

by Norman G. Hoffmann, Ph.D.

BENEFITS

- **Quick assessment of current substance abuse/dependence criteria**
- **DSM-IV criteria facilitate some diagnostic determinations in minutes**
- **Documentation of negative findings for those who deny problems**

The TAAD is a very brief, structured interview covering current alcohol and drug problems related to the DSM-IV criteria for abuse and dependence. It is designed as a basic triage to provide more than a screen but less than a comprehensive diagnosis. As a triage, the TAAD can identify obvious cases and provide substantial support for the diagnosis. In clearly negative cases, the TAAD provides documentation of negative responses to some of the more prevalent indications of abuse and dependence. For the remaining cases, problems will be indicated, but further comprehensive assessment will be required to make a definitive determination.

APPLICATIONS: The TAAD is intended for use in situations where a basic face-to-face screen or triage for a current diagnosis is desired with a minimum time commitment. It is ideal as a follow-up to a screen, such as a positive breath or urinalysis, when the basic question is whether a current diagnosis is likely. This instrument could also be used by a technician in medical settings to determine when a clinician with expertise in chemical dependency should be consulted.

ADMINISTRATION: The TAAD is intended to be presented as an interview and not as a pencil-and-paper instrument. In some cases, it may be necessary to clarify a question or to rephrase one to help the respondent understand what is being asked. However, such modifications should be kept to a minimum. A specific drug may be substituted for the generic term "drugs" in each question if the respondent indicates use of only one drug other than alcohol, or if a specific drug is the only one of interest. If the respondent denies use of other drugs, the interviewer should drop the reference to drugs in all questions. The instrument can be administered by any staff person with good interviewing skills, but interpretation is reserved for qualified licensed professionals.

TIME REQUIREMENTS: The TAAD will typically require 10 or fewer minutes to complete. Scoring should take no more than 2 or 3 minutes.

SCORING AND INTERPRETATION: The results of the TAAD scoring can be coded in the template at the back of the interview. In most cases, a positive diagnosis for dependence for a given substance will be indicated if at least three DSM-IV categories are covered by at least six positive responses to the TAAD items. A diagnosis for dependence may be indicated with fewer than six items if additional evidence suggests that the events constitute a clear pattern. In all cases, only the clinician can make the final determination of whether a diagnosis is indicated, based on all the evidence available.

COPYRIGHT: The TAAD is copyrighted by Norman G. Hoffmann and may not be photocopied or adapted. To do so is a violation of copyright law and constitutes unprofessional conduct.

TAAD Introductory Kit (Manual plus five TAAD interview forms)	TAAD-IK	$24.00
TAAD forms (packet of 30)	TAAD	$62.50

evince
clinical assessments

Evince Clinical Assessments
PO Box 17305
Smithfield, RI 02917
Tel: 800-755-6299, 401-231-2993
Fax: 401-231-2055

TAAD

Triage Assessment for Addictive Disorders

Norman G. Hoffmann, Ph.D.

Name: ______________________ Date: ______________ Interviewer: ______________

ID #: ___ ___ ___ / ___ ___ / ___ ___ ___ ___ Age: ________ Sex: __ (1) Male __ (2) Female

Ethnic Background (check one): __ (1) Asian __ (2) African-American __ (3) Hispanic / Latino

__ (4) Native American __ (5) White/Caucasian __ (6) Biracial / Other

Highest Grade Completed (circle): 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

Darken the circle indicating the respondent's best answer to each question. Each question should be asked with regard to the past 12 months.

1. In general, how often do you drink?
   - ① Daily
   - ② 4 to 6 days per week
   - ③ 2 to 3 days per week
   - ④ About once a week
   - ⑤ At least 12 times a year
   - ⑥ Less often
   - ⑦ Never (*Go to # 3*)

2a. **During the past 12 months,** did you ever drink at least a fifth of liquor in one day? (That would be about 20 mixed drinks, three bottles of wine, or three six-packs of beer.)
   - ① No
   - ② Yes

2b. When you drink, how many drinks do you usually have?
   - ① 7 or more
   - ② 5 or 6
   - ③ 3 or 4
   - ④ 1 or 2

2c. Can you drink more now without feeling the effects than you once did?
   - ① No
   - ② Yes

3. How often do you use other drugs?
   - ① Daily
   - ② 4 to 6 days per week
   - ③ 2 to 3 days per week
   - ④ About once a week
   - ⑤ At least 12 times a year
   - ⑥ Less often
   - ⑦ Never (*Go to # 5*)

4. Do you need larger amounts of drugs to get high than you once did?
   - ① No
   - ② Yes

5. **During the past 12 months,** have you frequently used alcohol/drugs to relieve emotional discomfort, such as sadness, anger, or boredom?
   - ① No
   - ② Yes (alcohol only)
   - ③ Yes (drugs only)
   - ④ Yes (both alcohol and drugs)

6. Have you frequently found yourself thinking about drinking/getting high?
   - ① No
   - ② Yes (alcohol only)
   - ③ Yes (drugs only)
   - ④ Yes (both alcohol and drugs)

7a. Have you occasionally had more to drink than you intended?
   - ① No (*Go to # 8*)
   - ② Yes

7b. How often would you say this happens?
   - ① Once a day
   - ② Several times a week
   - ③ Several times a month
   - ④ Several times a year

8. **During the past 12 months,** have you set rules to limit your drinking or drug use that you failed to follow?
   - ① No
   - ② Yes (alcohol only)
   - ③ Yes (drugs only)
   - ④ Yes (both alcohol and drugs)

SAMPLE

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Darken the circle for the best answer to each question.

9. Have you ever wanted to stop drinking /using drugs but couldn't?
① No
② Yes (alcohol only)
③ Yes (drugs only)
④ Yes (both alcohol and drugs)

10. Have you ever had any shakes, nausea, or other symptoms of withdrawal when you stopped drinking or using drugs?
① No
② Yes (alcohol only)
③ Yes (drugs only)
④ Yes (both alcohol and drugs)

11a. **During the past 12 months,** have you ever had a drink to ease a hangover?
① No
② Yes

11b. Have you used any drug to make withdrawal symptoms go away?
① No
② Yes

12. **During the past 12 months,** did drinking or drug use cause any physical problems, such as numbness, ulcers, or nasal problems?
① No
② Yes (alcohol only)
③ Yes (drugs only)
④ Yes (both alcohol and drugs)

13. Have you continued to drink/use drugs when you had a medical condition that might be made worse by it?
① No
② Yes (alcohol only)
③ Yes (drugs only)
④ Yes (both alcohol and drugs)

14. **During the past 12 months,** have you had any emotional problems when using alcohol or drugs?
① No
② Yes (alcohol only)
③ Yes (drugs only)
④ Yes (both alcohol and drugs)

15. **During the past 12 months,** have you neglected any responsibilities when drinking/using other drugs?
① No
② Yes (alcohol only)
③ Yes (drugs only)
④ Yes (both alcohol and drugs)

16. Has anyone objected to your drinking/drug use?
① No
② Yes (alcohol only)
③ Yes (drugs only)
④ Yes (both alcohol and drugs)

17. **During the past 12 months,** have you gotten into arguments while drinking/using drugs or had arguments about your drinking/drug use?
① No
② Yes (alcohol only)
③ Yes (drugs only)
④ Yes (both alcohol and drugs)

18. Has your drinking or drug use damaged a relationship with someone you cared about?
① No
② Yes (alcohol only)
③ Yes (drugs only)
④ Yes (both alcohol and drugs)

19. **During the past 12 months,** have you missed work or school because of your drinking/drug use?
① No
② Yes (alcohol only)
③ Yes (drugs only)
④ Yes (both alcohol and drugs)

20. Have you had any other problems at work or school because of your drinking/drug use?
① No
② Yes (alcohol only)
③ Yes (drugs only)
④ Yes (both alcohol and drugs)

21. **During the past 12 months,** have you had an injury that required medical attention when you were drinking /using drugs?
① No
② Yes (alcohol only)
③ Yes (drugs only)
④ Yes (both alcohol and drugs)

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Darken the circle for the best answer to each question.

22. Have you had a motor vehicle accident after you had been drinking/using drugs?
    - ① No
    - ② Yes (alcohol only)
    - ③ Yes (drugs only)
    - ④ Yes (both alcohol and drugs)

23. During the past 12 months, have you frequently driven when under the influence of alcohol/drugs?
    - ① No
    - ② Yes (alcohol only)
    - ③ Yes (drugs only)
    - ④ Yes (both alcohol and drugs)

24. Have you been ticketed or arrested for driving while under the influence?
    - ① No
    - ② Yes (alcohol only)
    - ③ Yes (drugs only)
    - ④ Yes (both alcohol and drugs)

25. Have you been arrested for any other reason related to alcohol/drugs?
    - ① No
    - ② Yes (alcohol only)
    - ③ Yes (drugs only)
    - ④ Yes (both alcohol and drugs)

26. During the past 12 months, did you ever drink/use drugs when you didn't intend to?
    - ① No
    - ② Yes (alcohol only)
    - ③ Yes (drugs only)
    - ④ Yes (both alcohol and drugs)

27. Have you stayed intoxicated or high for more than a day?
    - ① No
    - ② Yes (alcohol only)
    - ③ Yes (drugs only)
    - ④ Yes (both alcohol and drugs)

28. How much total time in a typical week do you spend drinking/using drugs, including the time to get over the effects of using?
    - ① More than 48 hours
    - ② 31 to 48 hours per week
    - ③ 21 to 30 hours per week
    - ④ 11 to 20 hours per week
    - ⑤ 5 to 10 hours per week
    - ⑥ Fewer than five hours per week

29. Have you given up or reduced social or recreational activities because of your drinking or drug use?
    - ① No
    - ② Yes (alcohol only)
    - ③ Yes (drugs only)
    - ④ Yes (both alcohol and drugs)

30. During the past 12 months, have you spent more time drinking/using drugs than you intended to?
    - ① No
    - ② Yes (alcohol only)
    - ③ Yes (drugs only)
    - ④ Yes (both alcohol and drugs)

31. For all the events we have discussed, how long ago was the most recent one?
    - ① Within a month
    - ② Within six months
    - ③ More than six months ago
    - ④ Does not apply

Which drugs, if any, were used in the past year:
- ① Marijuana
- ② Cocaine (powder or crack)
- ③ Stimulants of any kind
- ④ Other

Comments:

Interviewer: ______________________________

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DSM-IV Diagnostic Indications

For each item endorsed, circle "A" if a positive response pertains to alcohol and "D" if the item is positive for any other drug(s). After scoring each item, count the number of positive responses for each dependency category for alcohol and enter each total in the appropriate box. Repeat this for drug dependence. If fewer than three categories are positive for both alcohol and drugs, repeat this procedure for abuse. Then see the DSM-IV criteria in the next column.

DSM-IV Dependence Indicators

Q #	Indication	Alcohol or Drug	DSM-IV Diagnostic Categories
1a2b	4+ days/wk & 5+ drinks	A	5
2a	Fifth/day	A	1 5
2b	5+ drinks per occasion	A	1
2c	Tolerance for alcohol	A	1
3	Drug use 2+ days/week	D	5
4	Tolerance for drugs	D	1
7	Drank more (than intended)	A	3
8	Set rules	A D	4
9	Unable to stop	A D	4
10	Withdrawal	A D	2
11a	Drink for hangover	A	2
11b	Drug use for withdrawal	D	2
12	Physical problems	A D	7
13	Continued use	A D	7
14	Emotional problems	A D	7
15	Neglect responsibilities	A D	6
19	Missed work/school	A D	6
26	Unintended use	A D	3
27	Extended intoxication	A D	
28	20+ hours/week of use	A D	5
29	Reduced activities	A	
30	Unintended time using	A D	3

Dependence Scoring	Dependence Categories						
DSM-IV Category	1	2	3	4	5	6	7
Alcohol Total							
Drug Total							

DSM-IV Abuse Indicators

Q #	Indication	Alcohol or Drug	DSM-IV Categories
15	Neglected responsibilities	A D	1
16	Objections by others	A D	4
17	Arguments	A D	4
18	Damaged relationship	A D	4
19	Missed work/school	A D	1
20	Problems at work/school	A D	1
21	Injury when using	A D	2
22	Motor vehicle accident	A D	2
23	Drove under the influence	A D	2
24	DUI arrest/ticket	A D	3
25	Other arrest (substance related)	A D	3

Abuse Scoring	Abuse Categories			
DSM-IV Category	1	2	3	4
Alcohol Total				
Drug Total				

The DSM-IV requires that at least three categories of events or behaviors specific to a given substance occur during the same 12-month period for an individual to be diagnosed as dependent on that substance.

Dependency Categories

1. Tolerance, as defined by either the need for markedly increased amounts or markedly decreased effect with continued use of the same amount.
2. Withdrawal, as indicated by either a characteristic withdrawal syndrome or the use of the substance or related drug to relieve or avoid withdrawal symptoms.
3. Taking the substance in larger amounts or over a longer period than intended.
4. Persistent desire or unsuccessful efforts to cut down or control substance use.
5. Spending a great deal of time obtaining, using, or recovering from effects of use. (Note: What constitutes "a great deal of time" is not specified by the DSM-IV.)
6. Giving up or reducing participation in important social, occupational, or recreational activities because of substance use.
7. Continued use despite knowledge of having a physical or psychological problem that is caused by use or is likely to be made worse by continued use.

The DSM-IV defines substance abuse as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by behaviors in at least one of four abuse categories. As with dependence, the pattern or patterns of problems must occur within a 12-month period.

Categories For Abuse

1. Failure to fulfill major role obligations at work, school, or home.
2. Use in situations where it is physically hazardous.
3. Legal problems as a result of use.
4. Continued use, despite persistent or recurrent social or interpersonal problems caused or made worse by use.

Distributed by: Evince Clinical Assessments
PO Box 17305
Smithfield, RI 02917
Tel: 800-755-6299 or 401-231-2993
Fax: 401-231-2055

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SAMPLE

Appendix V-C:
New Jersey Substance Abuse Assessment Form

Effective 6-11-99
Replaces New

DYFS Form 11-47, Substance Abuse Assessment Form

PURPOSE

The purpose of the form is to provide a uniform, statewide procedure for the referral of DYFS clients in need of a substance abuse evaluation. Use of uniform criteria and protocols in the referral, assessment, diagnosis, level of care recommendation and identification of potential risk of harm to a child due to a parent/caretaker's substance use disorder enables all DYFS clients to receive the same services.

USE

DYFS Form 11-47, Substance Abuse Assessment Form is used to collect information necessary for referral of a client to a Certified Alcohol/Drug Counselor (CADC) for a complete bio-psycho-social assessment to determine the extent and severity of a suspected substance use problem.

INSTRUCTIONS FOR COMPLETING THE FORM

General Instructions

The DYFS Case Manager completes only Section I (page 1) of the form for any case being referred to a community-based substance abuse treatment provider. The entire form, with a completed DYFS Form 11-46, Substance Abuse Assessment Referral Form, is forwarded to the supervisor. The supervisor reviews and approves page 1, Section I of the DYFS Form 11-47, when applicable. The supervisor forwards the entire assessment form and the completed DYFS Form 11-46 to the designated DYFS office gatekeeper who prioritizes the referral and forwards both forms to the in-house CADC or a community-based substance abuse treatment provider.

The in-house CADC or community-based substance abuse treatment provider completes DYFS Form 11-47 and forwards the form back to the DYFS Case Manager and Supervisor who review, sign and date the assessment form.

SECTION I (page 1:Completed by DYFS Case Manager or community-based substance abuse treatment provider. See General Instructions)

Date: Enter the date page 1 is completed.

Case Name:	Enter the name of the DYFS case as registered on SIS.
KC #:	Enter the DYFS KC number.
Name of Person Referred Address/Phone#:.	Enter the name, address and telephone number of the DYFS client being referred for a substance abuse assessment.
Age/DOB/Sex/Race/SS #:	Enter the age, date of birth, sex, race and social security number of the DYFS client being referred.
Marital Status:	Check the appropriate marital status of the DYFS client.
Work Phone #:	Enter the telephone number where the DYFS client works, if applicable.
Insurance/Medicaid #/ID Number:	Enter the name of the DYFS client's health insurance program. Include the Medicaid number, if applicable, or health insurance program identification number.
Litigation Case:	Circle 'yes' or 'no' to indicate if the DYFS client's case is in litigation, i. e., termination of parental rights.
TANF/GA eligible:	Circle 'yes' or 'no' to indicate if the DYFS client is Eligible (verified) for Temporary Assistance to Needy Families (TANF) or General Assistance (GA) benefits.
Next of Kin:	Enter the name and relationship of the person the DYFS client provides as the closest relative.
In Case of Emergency:	Enter the name and relationship of the person to be contacted in case of an emergency with the DYFS client.
Referring Agency Name:	Enter the name of the DYFS District/ARC Office making the referral.
Client's Understanding...:	Enter a statement that describes the client's understanding of the reason for being referred for a

	substance abuse assessment. Include the client's perception of what is the presenting problem.
Employer Name:	Enter, if applicable, the name, and current or most recent, address of the employer of the DYFS client.
Medical Conditions:	List any health problems/medical conditions the DYFS client reports to have, including if client is currently pregnant.
Medications Taking:	List medications (prescription and non-prescription) the DYFS client reports to be currently using.
Previous Treatment:	Enter any prior psychiatric, psychological, substance abuse or codependency treatment/counseling the client reports. List the name(s) of the agency(ies) and a contact person (if known) where the client received treatment/counseling.

The DYFS Supervisor (only for referral to a community-based substance abuse treatment provider):

a. reviews and approves page 1, Section I of DYFS Form 11-47 and

b. forwards the entire assessment form and the completed DYFS Form 11-46 to the designated DYFS office gatekeeper.

The DYFS office gatekeeper (i.e., Casework Supervisor):

a. prioritizes the referral based on the priority level checked on DYFS Form 11-46 and

b. forwards both forms to the in-house CADC or

c. if no in-house CADC assigned, forwards DYFS Forms 11-46 and 11-47 to a community-based substance abuse provider.

SECTION II (page 2)

The in-house CADC or community-based substance abuse treatment provider completes Section II, Substance Use History with the referred DYFS client using clinically articulate comments specific to the client's responses to the questions.

SECTION III (pages 3-5)

The information below is gathered by the CADC or community-based substance abuse treatment provider in an interview/discussion with the client.

The in-house CADC or community-based substance abuse treatment provider:

a. enters the DYFS client's family history (page 3),

b. enters the DYFS client's psychological history (page 4),

c. enters the DYFS client's social/academic/vocational history (page 4-5),

d. enters the DYFS client's medical history (page 5) and

e. enters the DYFS client's legal history (page 5).

SECTION IV (page 6)

The in-house CADC or community-based substance abuse treatment provider completes the Multi-Dimensional Evaluation portion of the assessment form indicating the level of severity in each of the six dimensions and providing detailed comments for each dimension.

The in-house CADC or community-based substance abuse treatment provider completes the Clinical Summary part of Section IV by integrating the data from Section II, Substance Abuse History with the DYFS client's current functioning and severity of addictive illness.

SECTION V (page 7)

The in-house CADC or community-based substance abuse treatment provider completes Section V, Diagnostic Impression/Recommendations as follows:

a. Completes the demographic information on the DYFS client: name, KC number, District/ARC Office, and the name and telephone number of the assigned DYFS Case Manager and Supervisor as indicated on DYFS Form 11-46, Substance Abuse Assessment Referral Form.

b. Circles the location where the assessment occurred.

c. Completes the multi-axial assessment information using the DSM-IV criteria as follows:

- AXIS I-clinical disorders (substance use disorders) includes the Diagnostic Code numbers and DSM-IV and i-e 303.90 Alcohol Dependence, etc.

- AXIS II-personality disorder-mental retardation deferred unless the Assessment is conducted by a physician.

- AXIS III-general medical conditions deferred unless the assessment is conducted by a physician.

- AXIS IV-psychosocial and environmental problems: Complete this section indicating the client's specific problem areas to determine stressors that exacerbate substance use. Check all that apply.

- AXIX V-Global Assessment of Functioning: Determine the DYFS client's current and recent past level of functioning as defined in the DSM-IV G. A. F Scale in order to establish the DYFS client's impairment in life area functions.

d. Completes the ASAM Key Placement Dimension by circling the dimension numbers (1-6) and identifying the corresponding severity profile.

e. Identifies the Optimal ASAM Level of Care using the results of the Key Placement Dimensions and Severity Profile appropriate to treat the severity of the DYFS client's substance use disorder.

f. Risk of Harm (refers to the potential risk of harm for child abuse/neglect posed by the client's substance use.): The CADC circles High for a DYFS client with a child in the home under school age who meets the criteria of DSM-IV for a diagnosis of a Substance Abuse or Dependence problem.

The DYFS Case Manager and Supervisor incorporate this information into their determination of Risk of Harm.

g. Recommendations: Provides specific treatment recommendations, i. e., names of treatment facilities that provide the level of care identified in the

Optimal Level of Care portion of Section V.

The CADC and the Clinical Supervisor sign and date page 7 of the assessment form.

PROCESSING and CONFERENCING THE ASSESSMENT FORM

The CADC forwards the completed DYFS Form 11-47 within 24 hours of the assessment to the DYFS Case Manager and Supervisor.

The DYFS Case Manager and Supervisor:

a. review the completed assessment form and

b. sign and date the assessment form.

The in-house CADC or community-based substance abuse treatment provider, in consultation with the DYFS Case Manager and Supervisor, conference the case. An initial DYFS Case Plan is developed by using the substance use assessment, DYFS Form 11-47 conducted by the CADC, the DYFS assessment and any other pertinent, collateral information. The Case Plan, DYFS Form 26-51d or e is discussed with the client who has the opportunity to provide input. The DYFS Case Manager and Supervisor maintain responsibility for the development of the final DYFS Case Plan and its implementation.

DISTRIBUTION

Original	-	DYFS case record
Copy	-	Substance Abuse Treatment Provider
Copy	-	Client

DYFS 11-47
Rev. 4-7-2000

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
Division of Youth and Family Services

Substance Abuse Assessment Form

SECTION I: **DYFS completes this section only for referral to a community-based substance abuse treatment provider. In all other cases, the in-house CADC completes this section.**

Date ________________

Case Name ______________________________________ KC # ______________

Name of Person Referred ____________________________ Phone #____________

Address ____

Age/DOB _______________ Sex ____ Race _____ SS # _____-___-_____

Marital Status (check one) ( )Married ( )Divorced ( )Single ( )Separated ( )Widowed

Work Phone # (if applicable) ____-____-______

Insurance ______________________Medicaid # ________________ID Number ____

Litigation Case (circle one) Yes No TANF/GA eligible (circle one) Yes No

Next of Kin____
(Name) (Relationship)

In Case of Emergency

____
(Name) (Relationship)

____
(Address)

Referring Agency Name____

Client's Understanding of Reason for Referral / Presenting Problem _________________

____

____

Employer Name (current or most recent)/Address ____________________________

____

Medical Conditions: (including current pregnancy, if applicable) __________________

____

Current Medications Taking ____

____

Previous Treatment (Psychiatric or Chemical/Codependency)

____
(Agency) (Contact Person)

____
(Agency) (Contact Person)

____
(Agency) (Contact Person)

DYFS 11-47
New 6-11-99

Client: ____________________
Case #: ____________________

SECTION II

Substance Use History

(M) Mild (Mod) Moderate (S) Severe

Substance	Type Name	Route	Frequency	Amount	Age of Onset	Date of Last Use	Client Identified Problem Level
ALCOHOL							
MARIJUANA							
COCAINE							
OPIATES							
HALLUCINOGENS							
INHALANTS							
SEDATIVES							
METHADONE							

Did tolerance levels change after client began using?
( ) Increased ( ) Decreased ( ) Increased then decreased ( ) Other __________

When did client realize that the above alcohol/drug use was a problem? __________

Counselor Comments:

DYFS 11-47
New 6-11-99

Client: ____________________
Case #: ____________________

SECTION III

Background Information

Family History:
(Familial alcohol/drug history, medical history, psychological/psychiatric history, treatment history)

Current members of household:

Name/Age/Relationship — Alcohol/Drug Use (check either or both)

1. ______________________________ ☐Y ☐N/☐Y ☐N
2. ______________________________ ☐Y ☐N/☐Y ☐N
3. ______________________________ ☐Y ☐N/☐Y ☐N
4. ______________________________ ☐Y ☐N/☐Y ☐N
5. ______________________________ ☐Y ☐N/☐Y ☐N

Who does Client trust with his/her children? ____________________

Is family member(s) or significant other willing to participate in treatment process?
Yes ___ No ___

If yes, list names: ____________________

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New 6-11-99

Client:________________
Case #:________________

SECTION III (cont'd.)

Psychological History:

Has Client ever experienced feeling depressed when not under the influence?
If yes, when and how often? ________________________________

Has Client ever had suicidal/homicidal ideation and/or attempts, hallucinations, flashbacks? If yes, when and how often?

Does Client have any sleeping/eating difficulties?____________________

Has the Client experienced any unusual and/or bizarre behaviors while under the influence (acting out, aggression)? If so, how is behavior expressed? ________________

Social/Academic/Vocational History:

What is Client's religion? __________ Does Client believe in a higher power? _Y _N
Explain: ________________________________

Is Client sexually active? ____Yes ____No Is it safe sex? _____Yes _____No

Explain: ________________________________

Has the Client ever been physically/sexually abused or has the Client ever physically/sexually abused anyone? ____________________

Has the Client served in the Military? ______Yes ______No

If yes, Branch of Service: __________ ____________________

Type of Discharge: ________________________________

Highest Level of Education: ____________ Vocational Training? ____________

Reading/Writing Difficulties? ____________________________

Is Client in need of further education/vocational training? _____Yes _____No

Type of educational/vocational training needed: ____________________

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New 6-11-99

Client:________________
Case #:________________

SECTION III-Social/Academic/Vocational History (cont'd.)

Does Client currently work? __Yes __No If yes, where?________________

List Work History: ________________

Type of work Client enjoys: ________________

List current skills, talents, aptitudes, interests:________________

List past skills, talents, aptitudes, interests:________________

Client's strengths are:________________

Client's limitations are:________________

Is Client willing to participate in the treatment process? ________________

Medical History

Has Client ever been treated and/or hospitalized for any condition/illness? If so, explain type of condition, where, when, and results:________________

Last Medical Examination:________________

Is Client presently on any medication(s)? ________________

Legal History

Has Client ever had legal difficulties? ________________

Does Client have a court case pending? ________________

Is Client presently on probation? If so, list name, address and phone number of probation officer:________________

Is Client court ordered to treatment? ________________

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Rev. 4-7-2000

Client: ______________________
Case #: ______________________

SECTION IV

MULTI-DIMENSIONAL EVALUATION:

Dimension 1, Acute Intoxication and/or Withdrawal Potential (risk):

____
____
____

Dimension 2, Biomedical Conditions and Complications: Are there current physical illnesses other than withdrawal that need to be addressed or which complicate treatment?

____
____
____

Dimension 3, Emotional/Behavioral Conditions and Complications: Are there current psychiatric illnesses or psychological or emotional problems that need to be addressed or which complicate treatment?______________________

____
____
____

Dimension 4, Treatment Acceptance/Resistance: Is the Client compliant to avoid a negative consequence or actively object to receiving treatment? ______________

____
____
____

Dimension 5, Relapse/Continued Use Potential: Is the Client in immediate danger of continued severe distress and drinking/drugging behavior? Does the Client have any recognition and understanding of, and/or skills for how to cope with his/her addiction problems and prevent continued use?______________________

____
____
____

Dimension 6, Recovery Environment: Are there any dangerous family members or significant others, or school/working situations threatening engagement and success? Does the Client have supportive friendship, financial or educational/vocational resources to improve the likelihood of successful treatment? ______________

____
____
____

DYFS 11-47
Rev. 4-7-2000

Client: ______________________
Case #: ______________________

Clinical Summary: (i.e., Elaborate Client's problems in each assessment dimension by a brief narrative summary that integrates past history with current functioning and severity)

DYFS 11-47
Rev. 4-7-2000

Client: ____________________
Case #: ____________________

SECTION V DIAGNOSTIC IMPRESSION / RECOMMENDATIONS

District/ARC Office ____________________ Referral Date: __________

Case Name: ____________________ KC #: __________

Case Manager: ____________________ Phone #: __________

Supervisor: ____________________ Phone #: __________

Assessment Conducted In (circle one): Home Hospital Office Other

Axis I: Diagnostic Code DSM-IV Name

____ ____ ____.____ ____ ____________________

____ ____ ____.____ ____ ____________________

Axis II: Deferred Axis III: Deferred

Axis IV: (check all that apply)

☐ Problems with primary support group
☐ Problems related to social environment
☐ Educational problems
☐ Problems with the legal system/crime
☐ Occupational problems
☐ Housing problem
☐ Economic problems

Axis V: G.A.F. Score-at time of admission: ___ G.A.F. Score-highest in past year ___

[Instructions: 1) indicate severity profile; 2) Circle key dimensions determining level of care placement.]

Key Placement Dimensions (circle numbers)	Severity Profile (check one) HIGH	 MED	 LOW
1. Acute intoxication and/or withdrawal potential	___	___	___
2. Biomedical conditions and problems	___	___	___
3. Emotional/behavioral conditions and problems	___	___	___
4. Treatment acceptance/resistance	___	___	___
5. Relapse potential/recidivism	___	___	___
6. Recovery environment/family support	___	___	___

Optimal Level of Care (check one)

___ Level 0.5 – Early Intervention
___ Level 1 – Outpatient Treatment
___ Level II.I – Intensive Outpatient
___ Level II.5 – Partial Hospitalization
___ Level III – Med. Monitored Intensive Inpt.
___ Level IV – Med. Managed Intensive Inpt.

Risk of Harm (circle one): HIGH MODERATE LOW

Recommendations (specify): ______________________________

____

____________	______	____________	______
CADC	Date	Clinical Supervisor	Date
____________	______	____________	______
DYFS Case Manager	Date	DYFS Case Supervisor	Date

Appendix V-D:
New Jersey Treatment Provider Progress Report

DYFS 11-48
New

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
Division of Youth and Family Services

Substance Abuse Treatment Provider Progress Report

For outpatient and residential treatment programs 0-31 days submit report biweekly.
For residential treatment programs 31 days and more submit report monthly.

Client Name____ Report Date______________
DYFS District/ARC Office ____
DYFS Case Manager ____
DYFS In-house CADC____
Treatment Provider/Counselor____
Admission Date_________________ Anticipated Discharge Date_________________

LEVEL OF CARE (check one)
Level I__ Detox__ Level II__ Level II.5__ Level III__ Level III w/children__

I OUTPATIENT PROVIDER: Client attendance: Regular___ Sporadic___
Number of treatment contacts scheduled____ Number attended___

TO BE COMPLETED BY ALL PROVIDERS

II URINE DRUG SCREENS: total #_________ #positive______ #negative_____
Date(s) of positive drug screens______________________ Substances______________________

III PSYCHOLOGICAL (circle appropriate number: 1=poor; 2=fair; 3=good)

a.	Self-esteem	1 2 3	f. Overall attitude	1 2 3
b.	Communication skills	1 2 3	g. Development of coping mechanisms	1 2 3
c.	Decision-making skills	1 2 3	h. Family relationships	1 2 3
d.	Level of responsibility	1 2 3	i. Age-appropriate behavior	1 2 3
e.	Interaction with peers	1 2 3	j. Knowledge of parenting skills	1 2 3

IV MOOD: ___fluctuates ___manic ___hostile ___depressed ___anxious

(check one for each category)

INSIGHT	ATTITUDE TOWARD SELF	THOUGHT PROCESS
____denies problem	____critical	____alert
____minimizes problem	____accepting	____confused
____accepts problem	____blames others	____realistic

ATTITUDE TOWARD TREATMENT/RECOVERY (check one)
___Defensive ___Open-minded ___Negative ___Positive ___Fluctuates

V COUNSELOR COMMENTS: ____
____
____
____
____

Treatment Counselor Signature ______________________________ Date ______

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR part 2) prohibit you from further disclosures of it without the specific consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Appendix VI-A:
Sacramento County Referral Form

Sacramento County
Department of Health & Human Services – Alcohol and Drug Bureau

Alcohol and Other Drug (AOD) Screening and Service Referral

Client Name: (last) ____________ (first) ____________ Date: ________

☐ Male ☐ Female DOB: ________ Race/Ethnicity ________ SSN: ____-____-______

Address: ____________________ Zip ______ Phone: ____________

Area of Residence: ☐ South ☐ Broadway/Oak Park ☐ Midtown ☐ Central (e.g. Arden) ☐ East (e.g. Rancho Cordova) ☐ Northwest (e.g. Del Paso) ☐ Northeast (e.g. Citrus Heights)

Staff Name: ____________ Code: ______ Phone: ______ FAX: ______

Department/Division: ____________ Program: ____________ Mail code: ______

Referral Source (if other than staff above): ____________ CalWORKs ☐ Yes ☐ No

AOD Screening and Basis for Further Assessment *(check all that apply)*

☐ CPS Assessment tool (specific to AOD use) indicates risk: ☐ low ☐ moderate ☐ high

☐ Screening tool (e.g. CAGE, SASSI, etc.) indicates AOD problem Tool used: ____________

Results: ____________________

☐ Behaviors related to AOD problems (specify): ____________________

☐ Other (specify): ____________________

Services Requested

☐ Assessment by the Alcohol and Drug Bureau

☐ Treatment Placement/Authorization by the Alcohol and Drug Bureau

☐ Other: ____________________

To expedite treatment placement/authorization by the Alcohol and Drug Bureau, staff who have completed Level I and II of AODTI training, have the option of completing the AOD Preliminary Assessment.

Authorization for Exchange of Information (42 C.F.R.)

Authorization is hereby given for the exchange of information regarding (client's name) ____________ between the Sacramento County Department of Health and Human Services Alcohol and Drug Bureau and ____________ for further assessment and/or treatment placement/treatment authorization or treatment status. This consent is subject to change and will expire one year from the date of signature.

Client's Signature ____________ Date ______ Staff's Signature ____________ Date ______

Original: Alcohol and Drug Bureau Mail to 13-149B or FAX to 874-9892

Copy: provider **Yellow: referral source** **Pink: client**

Appendix VI-B:
Sacramento County Assessment and Treatment Authorization Form

Sacramento County
Department of Health & Human Services – Alcohol and Drug Services Division

Alcohol and Other Drug (AOD) Preliminary Assessment

Client Name: (last) ______________ (first) ______________ Date: ______ ______
Please Print Please Print

☐ Male ☐ Female DOB: __________ Race/Ethnicity: __________ SSN: ______-_____-______

Address: ______________________________ Zip ______ Phone: ______________

Area of Residence: ☐ South ☐ Broadway/Oak Park ☐ Midtown ☐ Central (e.g. Arden)
☐ Northwest (e.g. Del Paso) ☐ Northeast (e.g. Citrus Heights) ☐ East (e.g. Rancho Cordova

Assessor's Name: ______________ Worker Code #: ______ Phone: ______ FAX: ______

Department/Division: ______________ Program: ______________ Mail code: ______

Referral Source: ______________________________ Phone: ______ FAX: ______

Prior assessments/approximate dates: ______________________________

Part I – Presenting Needs: ______________________________

Part II – Insurance/Income Source: ______________________________ **CalWORKs** ☐ **Yes** ☐ **No**

Part III – Immediate Need Triage (if yes, explain in comments section)

Yes No
☐ ☐ A. Client has history of life-threatening withdrawal symptoms
☐ ☐ B. Client has current, life-threatening withdrawal symptoms
☐ ☐ C. Client has current, severe and untreated physical health problems

Yes No
☐ ☐ D. Client is in imminent danger of hurting self or others
☐ ☐ E. Client has current, acute psychotic symptom.

Comments for Part II: ______________________________

____

Part IV – AOD Use Information

(*check all that apply and indicate* ***age at initial use, date last used,*** *and* ***frequency and quantity of use)***

	Age @initial use	Date last used	Frequency/ Quantity		Age @initial use	Date last used	Frequency/ Quantity
☐ methamphetamine				☐ hallucinogens			
☐ cocaine/crack				☐ marijuana			
☐ other stimulants				☐ tobacco			
☐ opiates				☐ prescription			
☐ alcohol				☐ non-prescription			
☐ PCP				☐ other (specify):			

AOD Use: ☐ associated with history of violence *(describe under comments)* ☐ not associated with history of violence

Comments for Part III: ______________________________

____

Part V – Level of Functioning in Relation to AOD Use

A. Check low, moderate or high level of functioning for each area. Definitions are as follows:
1. **Low Functioning** - severe difficulty or impairment with serious and persistent signs and symptoms
2. **Moderate Functioning** - moderate difficulty or impairment with moderate to serious signs and symptoms
3. **High Functioning** - minimal difficulty or impairment with no or minimal signs and symptoms

	Low*	Moderate	High	Comments/Special Needs and/or Strengths*
1. Health status				
2. Emotional stability				
3. Family relations				
4. Social supports				
5. Legal problems				
6. Job/Education				
7. Housing				

***Requires explanation in comment section.**

B. Staff assessment of 1 through 7 determines overall biopsychosocial functioning as:
☐ low ☐ moderate ☐ high

Part VI– Assessment of AOD Severity

A. Client self-assessment *(check one)*

☐ No AOD use ☐ Use with no AOD related problems ☐ Use with AOD related problems

B. Staff assessment *(check one)*

☐ No AOD use
☐ User (occasional use with no or minimal AOD related problems)
☐ User (regular use with no or minimal AOD related problems)
☐ Substance abuser (frequent and/or periodic excessive use associated with AOD related problems)
☐ Chemically dependent in recovery (prior obsessive and compulsive use with significant AOD related problems)
☐ Chemically dependent not in recovery (obsessive and compulsive use with significant AOD related problems)

Part VII – Additional Information

Yes	No		
☐	☐	A.	Client is either an injection drug user, HIV positive, or pregnant (indicate due date) ____________
☐	☐	B.	Client is receiving services from one or more of the following: ☐ CPS ☐ CalWORKs ☐ Probation ☐ Parole ☐ Mental Health ☐ Public Health ☐ Other: ________
☐	☐	C.	Client has been formally diagnosed as having a mental illness specify diagnosis: ____________ specify medication: ____________
☐	☐	D.	AOD services are court ordered. What source? ____________
☐	☐	E.	Client is/or is likely to be court ordered to drug test.
☐	☐	F.	Client is/or is likely to drug test as a condition for employment.
☐	☐	G.	Client has ___ # children under 18 years of age.
☐	☐	H.	In CPS, client has ___# children with family ___# in foster homes (out of home placement).
☐	☐	I.	Client is motivated to participate in AOD services.
☐	☐	J.	Client is Medi-Cal eligible.
☐	☐	K.	Client has been provided with referrals for interim services *(check all that apply)*: ☐ pre-treatment group (specify): ____________ ☐ self-help service (specify): ____________ ☐ other (specify): ____________

Part VIII – Treatment History: ____________

Part IX – Comments: ____________

Part X - Authorization for Exchange of Information (42 C.F.R.)

Authorization is hereby given for the exchange of information regarding (client's name) ____________ between the Sacramento County Department of Health and Human Services Alcohol and Drug Services Division and ____________ for further assessment, treatment placement, treatment authorization, payment or treatment status. This consent will expire one year from the date of signature or upon client's request for change.

Client's Signature	Date	Assessor's Signature	Date

Original: Alcohol and Drug Services Division

Mail to 13-149D or FAX to 874-9806

Copy: provider **Yellow: referral source** **Pink: client**

Sacramento County
Department of Health & Human Services – Alcohol and Drug Bureau

Alcohol and Other Drug (AOD)
Treatment Placement and Authorization

Client Name: (last) ____________________ (first) ____________________ Date: ____________________
Please Print / Please Print

☐ Male ☐ Female DOB: ____________________ SSN: ______-_____-________

Recommended AOD Treatment Placement

Provide name, address, phone, date, time, etc. for each service category used. If more than one service is recommended, **numerically prioritize** and indicate the admission status.

1. ___ Further assessment: ____________________
2. ___ Pre-Treatment group: ____________________
3. ___ DHHS brief services: ____________________
4. ___ Self-Help: ____________________
5. ___ Outpatient counseling (under 3 hours weekly): ____________________
6. ___ Intensive outpatient counseling (3 to 8 hours weekly): ____________________
7. ___ Day treatment (9 to 20 hours weekly): ____________________
8. ___ Residential: ____________________
9. ___ Detoxification: ____________________
10. ___ Methadone detoxification or maintenance: ____________________
11. ___ Options for Recovery (specify modality): ____________________
12. ___ Other: ____________________

Comments: ____________________

TB assessment discussed ☐ (Client's initials)
Co-pay discussed ☐ (Client's initials)

Treatment Authorization

Signature: ____________________ **Date sent to referral source:** ____________________

Authorization for Exchange of Information (42 C.F.R.)

Authorization is hereby given for the exchange of information regarding (client's name) ____________________ between the Sacramento County Department of Health and Human Services Alcohol and Drug Services Division and ____________________ for further assessment, treatment placement, treatment authorization, payment or treatment status. This consent will expire one year from the date of signature or upon client's request for change.

Client's Signature ____________________ Date
Assessor's Signature ____________________ Date

Original: Alcohol and Drug Services Division
Mail to 13-149D or FAX to 874-9806

Copy: provider Yellow: referral source Pink: client

FORM CS199 (Rev. 1/01)

Appendix VI-C:
Sacramento County CADDS Supplement Form

SACRAMENTO COUNTY ALCOHOL AND DRUG BUREAU
CADDS SUPPLEMENT

1. Participant ID: ☐☐-☐-☐☐-☐☐-☐☐ **2. Form serial # :** ☐☐☐☐☐☐☐

3. Last 4 digits of Participant Social Security #: ☐☐☐☐

4. Treatment paid by: ☐ 1-Public Pay 2-Partial Public and Private Pay 3-Private Pay 4-Medi-Cal 5-No Pay

6. Discharge date from the last treatment program: ☐☐-☐☐-☐☐☐☐

5. Substances Used (number of days used within the past 30 days)	Admission	Discharge
Alcohol		
Alcohol to intoxication		
Heroin		
Methadone		
Other Opiates/Analgesics		
Sedatives-Hypnotics-Tranquilizers		
Cocaine/Crack		
Amphetamines - Methamphetamines		
Marijuana/Hashish		
Hallucinogens		
Inhalants		
Tobacco		
More than one substance per day		

Admission		**7. System Involvement**	Discharge	
YES	NO		YES	NO
		Criminal Justice		
		Child Welfare/CPS		
		Home Visitation		
		Public Health		
		Mental Health		
		Adult Services/IHSS		
		Housing Assistance		
		CalWORKs		
		Vocational/Educational		
		General Assistance		
		SSI/SDI		
		Case Management		

9. Unsatisfactory Discharge

If discharge was unsatisfactory identify reason.

(CADDS Item # 29 = 3)

1. Reason unknown
2. Walk-off, or drop out, etc.
3. Admitted to psychiatric facility
4. Admifted to medical facility
5. Incarcerated
6. Administrative discharge, non-compliance
7. Deceased
8. Other (specify below)

Enter one code ☐

8. Admission 30 days	**8. Admission** 6 months		**10. Discharge** 30 days only
		1. How many times have you been to a hospital emergency room in the past…	
		2. How many days have you stayed overnight in a hospital for medical problems in the past…	
		3. How many times have you been to an emergency psychiatric facility in the past…	
		4. How many days have you stayed overnight in a hospital for psychiatric problems in the past…	
		5. How many days have you participated in self-help services in the past…	
		6. How many times have you been arrested in the past…	
		7. How many days have you spent in jail or prison in the past…	
		8. How many days have you spent in involuntary detox in the past…	
		9. How many days have you been homeless in the past…	
		10. How many days have you lived with someone with an AOD problem in the past…	
		11. How many days did you have serious conflicts with your family in the past…	
		12. How many days did you have serious conflicts with other people in the past…	

	13. How many people, who are not AOD abusers can you turn to when in need of help?	
	14. How many children do you have, aged 17 or less (birth or adopted) - whether they live in home or not?	
	15. How many children, aged 17 or less are living in your household?	
	16. How many of your children are living with someone else because of a child protection court order?	
	17. How many of your children, living with someone else, have had your parental rights terminated?	

BEST COPY AVAILABLE

Pink: Provider Copy

INSTRUCTIONAL and OPERATIONAL DEFINITIONS

1. **Client ID:** enter the same identifying numbers as item # 3 on the CADDS.
2. **Form serial #:** enter the serial number from the CADDS form filled out for the client.
3. **Social Security #:** enter the last four digits of the client's social security number only.
4. **Treatment paid by:**
   1. Public Pay: payment from public sources excluding Medi-Cal.
   2. Partial Public and Private Pay: any combination of public (excluding Medi-Cal) and private pay
   3. Private pay: any type of non-public pay.
   4. Medi-Cal: only Medi-Cal payments.
   5. No pay: there is no payment source yet the treatment is provided.
5. **Substances Used (at Admission and Discharge):** for each substance listed enter the number of days the client used the substance in the last 30 days. If substance not used, use "0".
6. **Discharge date from the last treatment program:** enter the date client was discharged from the most recent treatment program participated in. Leave blank if not applicable.
7. **System Involvement (at Admission and Discharge):** enter a ☒ for yes or no for each of the services listed. Services could be from any county, not just Sacramento County. The following are the types of services listed.

Criminal Justice	incarceration, arrest, parole, probation, diversion
Child Welfare/CPS	foster care, child protective services, family maintenance, family preservation, guardianship, adoption
Home Visitation	services that are received through programs such as the Birth and Beyond project
Public Health	services from any public health treatment provider, clinic, or agency
Mental Health	services from any mental health treatment provider, hospital or clinic
Adult Services/IHSS	services received from adult protective services, conservatorship, in-home support services
Housing Assistance	services and support for housing assistance including rent subsidies, vouchers, temporary assistance
CalWORKs	services provided through Department of Human Assistance, welfare-to-work, CalWORKs (formerly AFDC) services
Vocational/educational	publicly funded vocational or educational training or support services
General Assistance	public assistance for adults meeting the eligibility requirements
SSI/SDI	Supplemental Security Insurance or Supplemental Disability Insurance
Case Management	services received to oversee the planning and management of client services, (e.g. parolee services, Options for Recovery, etc.)

8.&10. Complete at admission and discharge (**Question #10 – only for prior 30 days**)

1. Enter number of times client has been admitted to an emergency room.
2. Enter the number of days the client has stayed overnight in a hospital for medical problems.
3. Enter number of times client has been to an emergency psychiatric facility.
4. Enter number of days client spent overnight in a hospital for psychiatric problems.
5. Enter number of days client participated in self-help services.
6. Enter number of times client has been arrested.
7. Enter number of days client spent in jail or prison.
8. Enter number of days client spent in involuntary detox (e.g. Inebriate Center).
9. Enter number of days client was homeless.
10. Enter number of days the client lived with someone with an AOD problem.
11. Enter number of days client had serious conflicts with their family.
12. Enter number of days client had serious conflicts with other people.

---

13. Enter **number of people**, who are not AOD users, client can currently turn to for support.
14. Enter **number of children** the client has (birth or adopted, including deceased) under 17 – whether they live in the home or not.
15. Enter **number of children** (related or not) under the age of 17 living in client's household.
16. Enter **number of client's children** living with someone else because of child protection court order.
17. Enter **number of client's children**, living with someone else have had client's parental rights terminated.

9. **Discharge:** Use only if discharge was unsatisfactory, enter appropriate code.

Appendix IX-A:
Fresno Risk Assessment Regarding Substance Abuse Risk

FAMILY ASSESSMENT ANALYSIS FACTORS

Precipitating Incident Factors (1-4)

1. Severity and/or Frequency of Abuse
2. Severity and/or Frequency of Neglect
3. Location of Injury
4. History of Abuse or Neglect

Child Assessment Factors (5-9)

5. Child's Age, Physical and/or Mental Abilities
6. Perpetrator's Access to Child
7. Child's Behavior
8. Child/Caretaker Interaction
9. Child's Interaction with Siblings, Peers or Others

Caretaker Assessment Factors (10-16)

10. Caretaker's Capacity For Child Care
11. Caretaker/Child Interaction
12. Caretaker/Caretaker Interaction
13. Caretaker's Parenting Skills/Knowledge
14. Caretaker's Substance/Alcohol Misuse
15. Caretaker's Criminal Behavior
16. Caretaker's Emotional and Mental Health

Family Assessment Factors (17-21)

17. Family Interactions/Relationships
18. Strength of Family Support Systems
19. History of Abuse/Neglect in Family
20. Presence of a Parent Substitute in the Home
21. Environmental Condition of Home

Family/Agency Interaction (22-23)

22. Caretaker's Cooperation with Agency Staff and/or Service Plan
23. Progress of Child/Family in Treatment

RISK ASSESSMENT DECISION-MAKING PROCESS

- Assessment of risk is an evaluation of a constellation of child, caretaker and family factors that serve to identify the level of risk in a family.
- Risk Assessment should not be viewed as a one-time only determination but rather as an ongoing evaluation that recurs every time a new piece of information is obtained and analyzed.
- The risk assessment decision-making process enables caseworkers and supervisors to focus on family strengths, as well as risk concerns.
- By making important distinctions among a discrete number of risk factors, the resulting risk assessment should in effect "drive" the intervention strategy selected to alleviate the recognized risk.
- It is important that all documented assessments be based on factual behaviors, statements or professional opinions that can be substantiated by case documentation or contact with collateral sources.
- Caseworkers completing the worksheet must view the risk variables as only suggestive guidelines or parameters, as caseworkers need to assess risk and service needs appropriate to the circumstances of each case.
- To arrive at an overall assessment of risk, there must be: (a) a review of the most critical areas of risk; (b) examination of family strengths, and a weighing of their interaction with critical risk factors; and then (c) consideration of available service resources.

14. CARETAKER'S SUBSTANCE/ALCOHOL MISUSE

HIGH RISK	MODERATE RISK	LOW RISK
Current drug/alcohol misuse or dependence has been admitted or verified and this dependence poses an immediate threat to the supervision of the child	Current drug/alcohol misuse or dependence has been admitted or verified, but does not constitute an immediate danger to child, although risk is present	No history of drug/alcohol dependency or misuse has been admitted or verified; former substance abuser has successfully completed a recognized treatment program (or has been actively involved in AA/NA); past or current alcohol abuse poses no risk to child
Caretaker's life revolves around the use or attainment of drugs or alcohol, endangering the child; substance misuse poses risk to family's financial resources and negatively affects caretaker's ability to meet basic needs of the child	Caretaker is currently experimenting with or using several substances; use tends to be episodic with no serious consequences or significantly reduced ability to parent; drug/alcohol abuse is not physically/ psychologically addictive at this time, but pattern of misuse may be escalating	Alcohol is consumed only in moderation and caretaker is in control of his/her actions
Caretaker needs treatment in order to satisfactorily care for child and refuses treatment or is a chronic treatment dropout; maintains frequent contact and/or strong identification with suspected drug/alcohol abusers, which endangers the child	Caretaker admits to current substance abuse and is reluctant to seek treatment; caretaker is periodically incapable of caring for child due to drug/alcohol misuse; ability to make or assure adequate child care arrangements is deteriorating	Caretaker has admitted to substance abuse, but is actively participating in recognized treatment program (or AA/NA); drug or alcohol misuse is present, but is not escalating and does not constitute any risk to the child

Appendix IX-B:
San Diego SARMS Progress Report Form

The Dependency Court RECOVERY PROJECT

SARMS TWICE-MONTHLY PROGRESS REPORT

Check if noncompliant report ☐

Report Period: From __________ To __________ Drug Court ☐

Name: ______________________________ **Petition #** __________________

Child(ren)'s name(s):

______________________________ ______________________________

______________________________ ______________________________

SARMS Recovery Specialist: ________________________________

Start Date: ________________ **Week:** ____________________ **Case #:** ________________

Alcohol/Drug Test Results		**Program Attendance**		**Program Compliance**	
Total tests:	__________	# Meetings required:	________	______	Good
Positive tests:	__________	# Meetings attended:	________	______	Fair
Failures to test:	__________	# Absences:	________	______	Poor
Non appearances:	__________				

# Client contacts this period: ________ Tests: ____________ Other: ______________

Progress Notes/Comments:

☐ Modified Recovery Service Plan (copy attached)

Social Worker: ____________________ Supervisor: ________________________

Attorney: ____________________

Appendix X-A:
Miami Dependency Drug Court and Provider MOU

DEPENDENCY DRUG COURT

Juvenile Court, Eleventh Judicial Court, In and for Miami-Dade County, Florida

Linkage Agreement and Memorandum of Understanding

The following is a referral/linkage agreement between the Dependency Drug Court Project (herein after referred to as "DDC") located at 2700 NW 36 Street, Suite 2-1, Miami, Florida 33142, and

____, located at
(Herein after referred to as "Provider")

____

This agreement shall be effective beginning: __________________ and establishes a reciprocal relationship which will facilitate professional, appropriate, effective, and confidential services to persons referred by DDC.

Provisions of this Agreement are herein set forth:

1. The DDC will provide screening and assessment for clients who enter the program. This procedure will include screenings for substance abuse problems, as well aas psychiatric disorders, motivation and readiness for treatment, risk for violence, medical problems and life-threatening illnesses. This project will also document involvement in the criminal justice system. After the initial transition to a substance abuse treatment facility the Court Evaluation Unit (CEU) will provide an in-depth psychological assessment consisting of emotional, cognitive, psychological, and parental funtioning assessments.
2. DDC will provide treatment referrals to treatment providers that are best suited to meet the needs of the clients.
3. DDC will provide a system of court monitored phases, appearances, rewards, sanctions, and frequent randomized urine toxicology screenings over a one year period.
4. DDC staff will include three dedicated case managers/counselors from the Department of Children and Families (DCF) and the Village, Inc. and four DDC Specialists who will provide case management services. These staff members will collaborate to develop a caseplan, maintain treatment records, monitor clients' progress, integrate treatment services, and provide after-care support services in community-based settings. The name of the Court staff will be provided to the providers.
5. At the time of the signing of this Agreement, the Provider shall provide to DDC written copies of: 1) the Provider's established policy regarding acceptance of potential clients; 2) any regulations regarding confidentiality; and 3) all regulations impacting treatment and client expectations. The Provider must be operating with a regular DCF license for Substance Abuse Services, in accordance with rule 65D-30 FAC. Providers operating with an interim license will not be Providers of services for DDC.
6. The Provider shall make all final determinations regarding the suitability of potential clients for a particular treatment modality consistent with the ASAM Criteria and DCF Utilization Management Protocols.
7. Once clients are deemed appropriate for treatment and a referral has been made, DDC

will provide all information regarding court-mandated terms of treatment to the Provider.

8. The Provider will adhere to treatment requirements as set forth in the court-mandated terms of treatment, but will make all other determinations regarding content and scope of treatment consistent with court-mandated terms of treatment. In case of disagreement between the Provider and DDC, the Court's view of whether a Provider's treatment is consistent with court-mandated treatment shall govern and/or an independent opinion will be sought from a qualified professional.
9. DDC will provide written authorization for release and disclosure of Confidential Alcohol and Drug Patient Information in accordance with Federal Regulation 42 CFR, Part 2.
10. The confidentiality and exchange of client information between DDC and the Provider shall be governed by regulations specified in DDC's consent forms and applicable Provider regulations.
11. For every client in DDC, the Provider will identify a liaison as well as a "back-up"with whom to exchange information and ensure consistent communication with DDC.
12. The Provider will supply verbal and written reports and accounts as set forth in the Information Exchange Requirements provided by DDC. Information will include, but is not limited to, attendance, scope of treatment, quality of participation, all urine dates and results, problems, achievements and treatment accomplishments, and interactions with clients' child(ren). Such information will be required at each court hearing. The frequence of court hearings is contained in the DDC protocol.
13. To the extent possible, DDC will endeavor to establish and maintain a partnership with the Provider where treatment decisions for specific clients are mutually acceptable and information is easily accesible.
14. To ensure a collaboration, the Provider is encouraged to initiate communication with the DDC regarding a client's treatment or any related issue as often as necessary.
15. To the extent possible, the Provider may seek to use DDC as a motivator for treatment compliance.

TERMINATION

This Agreement may be terminated by either party upon written notification and shall be effective thirty (30) days from receipt of such notification. Termination of Agreement shall not require the termination of existing clients. Said client shall continue to receive services in accordance with the terms set forth in this Agreement until such time the client is no longer under the supervision of DDC. The undersigned agrees to implement the terms of this Agreement within their respective agencies.

____________________ Print Name & Title (on Behalf of DDC)	____________________ Print Name & Title (on Behalf of the Provider)
____________________ Signature	____________________ Signature
____________________ Date	____________________ Date

Appendix X-B:
Miami Authorization for Release of Confidential Information

Eleventh Judicial Circuit of Florida - Juvenile Division

DEPENDENCY DRUG COURT

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF CONFIDENTIAL ALCOHOL AND/OR DRUG ABUSE PATIENT INFORMATION

I, ______________________________, ID # ______________
(PRINT CLIENT NAME)

and on behalf of my minor children, ______________________________
(PRINT NAMES OF CHILDREN IF APPLICABLE)

do hereby authorize the Dependency Drug Court (DDC) and staff thereof, to receive and exchange

information with ______________________________
(Print Name and Address of Program/Facility/Organization)

____
(Print City, State, Zip Code)

I understand that information pertaining to my attendance and progress in treatment is protected by Federal Regulation 42CFR, Part 2, "Confidentiality of Alcohol and Drug Abuse Patient Records" and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I willingly and voluntarily authorize to disclose information regarding both my and my children's previous treatment episodes, current and previous substance abuse history, current need for treatment as well as progress, attendance and degree of participation in any treatment or components thereof as mandated by the Court, to the Judge, case managers, health staff and employees and partners of the DDC as necessary to monitor my court mandated treatment. Should I be mandated to attend treatment or services with my children, I hereby authorize that the above agency release all necessary information to the listed parties for ongoing monitoring of the child's status. I further allow for the information's re-disclosure to my attorney, Florida Children and Family Services (DCFS) and its contract agencies including foster care agencies, the Legal Aid Society, Florida Division of Parole, Florida Department of Probation, and the Florida State Criminal and Supreme Courts, if applicable.

The extent of the information to be released and disclosed in my (and/or my children's) diagnosis, attendance, scope of treatment, treatment progress and quality of participation, dates and results of urinalysis testing, and termination or completion of my treatment.

The purpose and need to disclose the above information is to comply with the conditions of my court mandate and to inform the listed parties of my ongoing participation in any mandated treatment so that the Court can make informed legal decisions in the best interest of my children. My consent for release of such information is limited to these purposed.

I understand that the information may affect the status and whereabouts of my children and may result in modifying the terms of Court orders and/or mandates the terms of my participation in a treatment program.

I understand that this consent will remain in effect and cannot be revoked by me until the Dependency Court has ended all Court monitoring of my case.

I understand that the recipients of this information may re-disclose it only in connection with their official duties and with respect to the terms of my Court mandated treatment and the well-being and best interests of my children as deemed by the Court.

______________________________ ______________
Client Date

______________________________ ______________
Witness Date

Appendix X-C:
Miami Treatment Progress Report

DEPENDENCY DRUG COURT
IN THE CIRCUIT COURT OF THE ELEVENTH JUDICIAL CIRCUIT IN AND FOR
MIAMI-DADE COUNTY, FLORIDA

WEEKLY TREATMENT PROGRESS REPORT

Date: ____________ **Noncompliant Report** ____

NAME OF CLIENT: ________________________ **CASE NUMBER #** ____________

CHILD(REN)' NAME(S): ____

____

Treatment Facility: ________________ **Treatment Modality:** ________________

Treatment Start Date: ________________

Primary Counselor/Telephone: ____

Report Period: From: __________ **To:** __________

DDC SPECIALIST: ________________________________

Day(s)of Week	Days Present	Days Absent	Days Excused Reason	Toxicology Date/Results	Progress of Groups/Individual/Workshops, Etc.

Number of client contacts this period: __________ Other(s): __________

rogress Notes/Comments:

IGNATURE DATE

LEASE RETURN FORM TO DDC SPECIALIST WITH A COPY OF THE CURRENT TREATMENT PLAN
ND THE DRUG SCREEN RESULTS.

REVISEDTXWEEKLY

Appendix X-D:
Miami Dependency Drug Court Sample Court Orders

☐ IN THE CIRCUIT COURT OF THE ELEVENTH JUDICIAL CIRCUIT IN AND FOR MIAMI-DADE COUNTY, FLORIDA
☐ IN THE COUNTY COURT IN AND FOR MIAMI-DADE COUNTY, FLORIDA

DIVISION	ORDER TO PARTICIPATE IN DEPENDENCY DRUG COURT	CASE NUMBER
IN THE INTEREST OF:	D.O.B.: A CHILD(REN)	CLOCK IN

THIS COURT, HAVING RECEIVED EVIDENCE IN THE ABOVE CAPTIONED MATTER, FINDS AS FOLLOWS:

You, ____________________________________, are NOTIFIED that you have agreed and been accepted to participate in the Dependency Drug Court (DDC). All further proceedings in this case shall be heard by Judge Jeri B. Cohen or her designee. The terms and conditions of participation are as follows:

You are ORDERED to: [1] participate in the in the DDC Program; [2] refrain from possessing, using, or consuming alcohol or illegal substances, or misusing prescription medications; [3] appear in Division 03 for hearings at the dates and times ordered by the Court; [4] submit to random DDC administered alcohol / drug tests and any additional tests ordered by the Court; [5] participate in all required DDC and treatment program activities; [6] attend all required meeting/counseling sessions; [7] comply with all rules of the Children and Families Case Plan (CFCP) and treatment program; [8] cooperate fully with the DDC Specialists, DDC staff, treatment program staff, and the Department of Children & Families (DC&F) Counselor; and [9] be completely honest and truthful in all of your communications with the Court.

Failure to comply with any part of this Order (i.e., a non-compliant event: a positive result from an alcohol/drug test ("dirty test); failure to appear for a court hearing; failure to appear for an alcohol/drug test ("no show); failure to attend required DDC and treatment program activities; failure to attend required meeting/counseling sessions; failure to comply with the rules of the Case Plan and treatment program; leaving treatment program; involuntary termination from the program; failure to comply with visitation of children; a dishonest statement to the Court; may result in a finding of contempt by this Court. If you are found in contempt, the Court may impose any sanction authorized by law, including, but not limited to:

- a verbal reprimand from the Court
- participation in mandatory motivational workshops
- increased in court appearances
- increased case management
- increased intensity of treatment program
- reduction in phase

- if participating in out-patient treatment, a referral to residential treatment
- from two (2) days in jail the first time with escalating sanctions up to 10 days
- dismissal from DDC
- recommendation to file for Termination of Parental Rights (TPR)

If a jail sanction is imposed, I will forfeit the right to a jury hearing.

IT IS SO ORDERED.

Date: ________________

____
Judge of the Circuit Court

I have read this Order. I have received a copy of this Order. I understand that this is a valid Order. I understand the penalties for a violation of this Order. I understand and freely give my consent that this is the only notice I will receive of the penalties.

Date: ________________

____
Name of Parent / Guardian (print)

____
Signature of Parent / Guardian

____
Signature of Parent / Guardian's Attorney (print).

____
Signature of Parent / Guardian's Attorney

IN THE CIRCUIT COURT OF THE
ELEVENTH JUDICIAL CIRCUIT IN
AND FOR MIAMI-DADE COUNTY,
FLORIDA

IN THE INTEREST OF:

JUVENILE/DEPENDENCY DIVISION

CASE NO.:

Child/Children

________________________________/

ORDER

It is hereby, ORDERED AND ADJUDGED that the Department of Children and Families provide the Dependency Drug Court with a copy of the Dependency Petition, as well as a copy of the client's criminal record, within five days. The Department of Children and Families will also provide the Dependency Drug Court with a Case Plan when signed.

DONE AND ORDERED this ____________ day of __________________, 1999.

____
JERI B. COHEN
CIRCUIT COURT JUDGE

IN THE CIRCUIT COURT OF THE
ELEVENTH JUDICIAL CIRCUIT IN
AND FOR DADE COUNTY, FLORIDA

IN THE INTEREST OF:

JUVENILE DIVISION

CASE NO: ______________

Children.

______________________________/

ORDER

It is hereby, ORDERED AND ADJUDGED that ______________________________ be ordered into continued treatment at ______________________________ until further notice of the Court.

DONE AND ORDERED in Chambers, Miami-Dade County, Florida this _______ day of __________________, 1999.

____
JERI B. COHEN
CIRCUIT COURT JUDGE

IN THE CIRCUIT COURT FOR THE
ELEVENTH JUDICIAL CIRCUIT IN AND
FOR MIAMI-DADE COUNTY, FLORIDA

IN THE INTEREST OF:

JUVENILE DIVISION

CASE NO.: D003

CHILD/CHILDREN

______________________________/

ORDER

As part of your participation in the Dependency Drug Court you are hereby ordered to:

______ Attend and participate in the Ages and Stages Program

______ Attend and participate in the Family Strengthening Program

DONE AND ORDERED in Miami-Dade County, Florida, this _____ day of _______, 1999.

____
JERI B. COHEN
CIRCUIT COURT

Copies furnished to all parties.

DEPENDENCY DRUG COURT

ADDENDUM TO CHILDREN AND FAMILIES CASE PLAN (CFCP)
SUBSTANCE ABUSE SECTION

DATE: ____________________ CASE NUMBER: ________________________

PARENT(S): ____

CHILD(REN): ____

1. The Parent(s) will abide by the terms and conditions in the "Order to Participate in the Dependency Drug Court (DDC) Program which was signed on ____________________.

2. The Parent(s) shall attend and successfully complete the DDC Substance Abuse Screening/Evaluation to evaluate the type and duration of the substance abuse treatment needed for the parents to become drug free. After the parent(s) submit(s) to the necessary evaluation, the DDC staff will make appropriate referrals for appropriate treatment.

3. The Parent(s) will not possess, use or consume alcohol or illegal substances, or misuse prescription medications.

4. _____ A. In an Out-Patient Treatment setting, participation in DDC will take place in four (4) phases for a period of one year. The first three (3) phases will consist of approximately two (2) months each, and the fourth (4) phase will consist of approximately six (6) months, at the discretion of the Court.

During Phase 1, Parent(s) will appear in Court for a review hearing (1) once a week.
During Phase 2, Parent(s) will appear in Court for a review hearing once every two (2) weeks.
During Phases 3 and 4, Parent(s) will appear in Court for a review hearing once a month.

____ B. In an In-Patient Treatment setting, participation in DDC will take place in four (4) phases (for a period of one year). For the first six (6) months (while in treatment), client will attend court appearances one time a month. Upon successful completion of six (6) months of treatment, the phasing period will begin. The first two (2) phases will consist of approximately two (2) months each, and the third and fourth phases will consist of approximately one month each, at the discretion of the Court.

During Phase 1, Parent(s) will appear in Court for a review hearing (1) once a week.
During Phase 2, Parent(s) will appear in Court for a review hearing once every two (2) weeks.
During Phases 3 and 4, Parent(s) will appear in Court for a review hearing once a month.

5. The Parent(s) shall submit to urinalyses testing for the duration of the Case Plan. The Parent(s) are to provide urine samples for testing two (2) times per week until further notice from the Court, or as many times as ordered by the Court.

ADDENDUM TO CHILDREN AND FAMILIES CASE PLAN (CFCP)
SUBSTANCE ABUSE SECTION

6. The Parent(s) shall attend and participate in required treatment sessions as deemed necessary by the Provider and the Court, and the Parent(s) shall participate in all required treatment program activities.

7. While the Parent(s) is in an outpatient drug treatment program, she/he will be required to attend ninety (90) meetings in ninety (90) days, of Alcoholics Anonymous (AA) Meetings and/or Narcotics Anonymous (NA) Meetings. The Parent(s) is not required to attend AA/NA meetings on the days that she/he participates in treatment.

8. Once the Parent(s) attends ninety (90) meetings in ninety (90) days, the frequency of attendance shall be decreased to three (3) times per week for the duration of the Case Plan.

9. The Parent(s) shall obtain a sponsor, and work the Twelve Steps in the AA/NA Program and be able to document her/his attendance at meetings.

10. The Parent shall attempt to be self-sufficient, and shall refrain from engaging in a new relationship for a period of one year.

11. The Parent(s) is required to pay child support to the custodian of the child/children. The amount shall be determined by the Court after all parties have submitted a financial affidavit.

12. The Parent(s) shall submit to a psychological evaluation with/at Dr. ____________________, on ____________________. The evaluation shall address issues relating to the issues that brought this case into the system and are also assessed by the tests administered during the evaluation process.

12. The Parent(s) shall obtain stable housing upon her/his release from the Residential Drug Treatment Program prior to any reunification or as determined by the Court.

13. The Parent(s) shall obtain stable employment upon her/his release from the Residential Drug Treatment Program and prior to any reunification or as determined by the Court.

14. The Parent(s) shall inform the Department of Children and Families and DDC within seventy two (72) hours of a change of address or change in telephone number.

15. The Parent(s) shall refrain from any criminal activity.

16. The Parent(s) shall attend and successfully complete the Ages and Stages Evaluation (children 0-4 years of age); the Strengthening Families Program; and/or parenting skills classes as required. Successful completion shall be verified in writing to the Department of Children and Families.

17. The Mother/Father shall attend and successfully complete a domestic violence counseling program, and will provide written documentation regarding the completion of that program to both DC&F and DDC.

DEPENDENCY DRUG COURT

ADDENDUM TO CHILDREN AND FAMILIES CASE PLAN (CFCP)
SUBSTANCE ABUSE SECTION

18. After the Mother/Father completes the Residential Drug Treatment Program, she/he will be required to pay child support to the custodian of the child/children.

19. The Parent(s) shall adhere to the rules of the Children and Families Case Plan (CFCP), and the rules of the treatment program.

20. The Parent(s) shall be compliant with her/his Case Plan.

21. The Parent(s) shall be compliant will other tasks identified in the Case Plan (i.e., ability to maintain employment, ability to maintain housing, maintaining consistent visitation with child(ren).

22. The Parent(s) shall attend, participate and successfully complete an Aftercare Substance Abuse Treatment Program.

JERI B. COHEN, CIRCUIT JUDGE

PARENT/GUARDIAN(MOTHER) & DATE	PARENT'S ATTORNEY (MOTHER) & DATE
PARENT/GUARDIAN(FATHER) & DATE	PARENT'S ATTORNEY (FATHER) & DATE
DEPT. OF CHILDREN & FAMILIES COUNSELOR & DATE	DEPT. OF CHILDREN & FAMILIES ATTORNEY & DATE

DEPENDENCY DRUG COURT SPECIALIST & DATE

Appendix X-E:
Miami Client Acknowledgment of Drug Court Procedures

☐ IN THE CIRCUIT COURT OF THE ELEVENTH JUDICIAL CIRCUIT IN AND FOR MIAMI- DADE COUNTY, FLORIDA
☐ IN THE COUNTY COURT IN AND FOR MIAMI-DADE COUNTY, FLORIDA

JUVENILE DIVISION	**ACKNOWLEDGMENT OF DEPENDENCY DRUG COURT PROCEDURES**	**CASE NUMBER**
IN THE INTEREST OF:	**D.O.B.:** **A CHILD(REN)**	**CLOCK IN**

Fill out this form if you wish to participate in Dependency Drug Court (DDC). Initial each item only if you understand it. If you have any questions about this form or your case, ask your lawyer, or the DDC Judge.

______1. I understand that my participation in DDC requires me to abide by the terms and conditions of the attached "Agreement to Participate in DDC."

______2. I understand that for each "non-compliant event," as described on the attached "Agreement to Participate in DDC," I will be subject to sanctions imposed by the Court.

______3. I understand that if I am found in non-compliance with DDC or the DC&F case plan, the court may impose any sanction that I voluntarily agreed to when I entered DDC, including from 2 to 10 days in custody. I understand that I forfeit my right to an evidentiary hearing regarding a positive alcohol or drug screen, unless I am contesting the accuracy of the urinalysis. In that case, I will be entitled to an additional drug test by an independent laboratory using the same specimen. I will also be entitled to an evidentiary hearing if the court has abused its discretion by not abiding by the sanctions set out in the Drug Court case plan. A jail sanction will not necessarily be predicated on a finding of indirect or direct criminal contempt. I will not be entitled to an evidentiary hearing to test the validity of the DDC Protocol since I am entering DDC voluntarily. I will be entitled to an evidentiary hearing if I am in violation of any of the other conditions of my DDC case plan.

______4. I understand that repeated "non-compliant events" (three or more) may result in the Department of Children and Families initiating a proceeding to terminate my parental rights.

______ 5. I understand that with repeated "compliant events," as described on the attached "Agreement to Participate in DDC," I may qualify for rewards granted by the Court.

______6. I understand that the DDC Judge has discretion to dismiss me from the DDC program at any time upon finding that I have not been honest and truthful with the Court.

______7. I understand that I still must comply with the court-ordered family reunification plan and appear at all court hearings even if I am later dismissed from DDC.

DATED: ____________ ____________________ Print Name of Participant ____________________ Signature of Participant

DATED: ____________ ____________________ Print Name of Participant's Attorney ____________________ Signature of Participant's Attorney

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☐ IN THE CIRCUIT COURT OF THE ELEVENTH JUDICIAL CIRCUIT IN AND FOR MIAMI-DADE COUNTY, FLORIDA
☐ IN THE COUNTY COURT IN AND FOR MIAMI-DADE COUNTY, FLORIDA

JUVENILE DIVISION	AGREEMENT TO PARTICIPATE IN DEPENDENCY DRUG COURT	CASE NUMBER
IN THE INTEREST OF:	D.O.B.: A CHILD(REN)	CLOCK IN

I AGREE TO THE FOLLOWING as conditions of my participation in Dependency Drug Court (DDC):

1. I will continue to abide by the terms and conditions in the "Order to Participate in the DDC Program," which I signed and received on (date): ________________.

2. Upon my acceptance into DDC, the Court will issue an "Order to Participate in DDC." My signature on this Agreement indicates my consent to the terms and conditions set forth on that Order.

3. I will not possess, use, or consume alcohol or illegal substances, or misuse prescription medications.

4. In an Out-Patient Treatment setting: My participation in DDC will take place in four phases (for a period of one year). The first three phases will consist of approximately two months each, and the fourth phase will consist of approximately six months, at the discretion of the court.

   During Phase 1, I will appear in Court for a review hearing once a week.

   During Phase 2, I will appear in Court for a review hearing once every two weeks.

   During Phases 3 and 4, I will appear in Court for a review hearing once a month.

5. In an In-Patient Treatment setting: My participation in DDC will take place in four phases (for a period of one year). For the first six months (while in treatment), I will attend court appearances one time a month. Upon successful completion of six months of treatment, the phasing period will begin. The first two phases will consist of approximately two months each, and the third and fourth phases will consist of approximately one month each, at the discretion of the court.

   During Phase 1, I will appear in Court for a review hearing once a week.

   During Phase 2, I will appear in Court for a review hearing once every two weeks.

   During Phases 3 and 4, I will appear in Court for a review hearing once a month.

6. I will submit to random alcohol/drug tests and any alcohol/drug tests ordered by the Court. If I am contesting a positive test result, the same urine sample will be sealed and sent to an independent laboratory.

7. My progress in recovery will be monitored by the DDC Specialist, who will submit progress reports to the Court and to the Department of Children & Families (DC&F). The progress reports will contain:

- the results of every alcohol/drug test
- attendance at required meetings and/or counseling sessions
- participation in required treatment program activities
- adherence to the rules of the Children and Families Case Plan (CFCP), and the rules of the treatment program
- compliance with my Case Plan

8. Each of the following achievements will be considered a "compliant event":

- attendance at court appearances
- a negative result from an alcohol/drug test
- compliance with submitting to all alcohol/drug tests
- attendance/participation at required meetings and/or counseling sessions
- attendance/participation at required treatment program activities
- compliance with the treatment program
- compliance with the Case Plan
- compliance with other tasks identified in the Case Plan (i.e., ability to maintain employment, ability to maintain housing, maintaining consistent visitation with child(ren))

9. For each "compliant event" any of the following rewards may be granted:

- acknowledgment by Judge
- reduced Court appearances
- reduced urine testing
- case called early in court
- increased/unsupervised visitation with child(ren)
- reunification with child
- an honor roll listing (kept in court)
- a phase advancement certificate in court
- graduation ceremony, including picture with the judge

10. Each of the following may be considered a "non-compliant event" at the discretion of the Judge.

- failure to make an appearance on time in court
- leaving treatment program
- involuntary termination from the program
- absconding with child(ren)
- a positive result from an alcohol/drug test (a "dirty test")
- failure to appear for an alcohol/drug test (a "no-show")
- failure to attend required meetings and/or counseling sessions
- failure to attend required treatment program activities
- failure to comply with the other tasks in the Case Plan
- failure to comply with the rules of the treatment program
- a dishonest statement (written or spoken) to the DDC Judge
- failure to attend visitation with children or attempting unauthorized visitation
- failure to comply with other tasks in RSP
- failure to perform sanctions

11. For each "noncompliant event," any of the following sanctions may be imposed:

- reprimand from court
- participation in motivational workshops
- increased court appearances
- increased case management
- increased intensity in treatment program
- reduction in phase
- if participating in out-patient treatment, a referral to residential treatment
- two (2) days in jail the first time with escalating sanctions up to 10 days
- recommendation to file for Termination of Parental Rights (TPR)

12. If a jail sanction is imposed, I forfeit the right to an evidentiary hearing unless I am contesting the validity of the urinalysis and/or the court's compliance with the DDC Protocol.

13. After consultation with my attorney, I have signed the "Acknowledgment of DDC Procedures" attached to this Agreement.

DATED: ____________________

____
Name of Participant (print)

____
Signature of Participant

Appendix XII-A:
Core Competencies for Children Affected by Substance Abuse

Core Competencies for Involvement of Health Care Providers in the Care of Children and Adolescents in Families Affected by Substance Abuse

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These competencies are presented as a specific guide to the core knowledge, attitudes, and skills which are essential to meeting the needs of children and youth affected by substance abuse in families.

There are over 28 million children of alcoholics in America; almost 11 million are under the age of eighteen. Countless other children are affected by substance-abusing parents, siblings or other caregivers. There is an association between child physical, emotional and sexual abuse and neglect, domestic violence, and substance abuse in the family. All children have a right to be emotionally and physically safe. No child of an alcoholic or other substance abusing parent should have to grow up in isolation and without support. Recognizing that no one is unaffected in families with substance abuse, health professionals should play a vital role in helping to optimize the health, well-being and development of children and adolescents from these families and should recognize, as early as possible, associated health problems or concerns.

It is the hope of the National Association for Children of Alcoholics(NACoA) that organizations representing health care professionals will adopt these competencies or competencies modeled from them. Developed by a multi-disciplinary professional advisory group to NACoA, these competencies set forth three levels for professional involvement with children who grow up in homes where alcohol and other drugs are a problem. All health care providers should aspire to Level I. Resources and programs should be made available for the training of professionals who desire to achieve competency at Levels II and III.

LEVEL I

For all health professionals with clinical responsibility for the care of children and adolescents:

1. Be aware of the medical, psychiatric, and behavioral syndromes and symptoms with which children and adolescents in families with substance abuse present.
2. Be aware of the potential benefit to both the child and the family of timely and early intervention.
3. Be familiar with community resources available for children and adolescents in families with substance abuse.
4. As part of the general health assessment of children and adolescents, health professionals need to include appropriate screening for family history/current use of alcohol and other drugs.
5. Based on screening results, determine family resource needs and services currently being provided, so that an appropriate level of care and follow-up can be recommended.
6. Be able to communicate an appropriate level of concern, and offer information, support, and follow-up.

LEVEL II

In addition to Level I competencies, health care providers accepting responsibility for prevention, assessment, intervention, and coordination of care of children and adolescents in families with substance abuse should:

1. Apprise the child/family of the nature of alcohol and other drug abuse/dependence and its impact on all family members and strategies for achieving optimal health and recovery.
2. Recognize and treat, or refer, all associated health problems.
3. Evaluate resources—physical health, economic, interpersonal, and social—to the degree necessary to formulate an initial management plan.
4. Determine the need for involving family members and significant other persons in the initial management plan.
5. Develop a long-term management plan in consideration of the above standards and with the child or adolescent's participation.

LEVEL III

In addition to Level I & II competencies, the health care provider with additional training, who accepts responsibility for long-term treatment of children and adolescents in families with substance abuse should:

1. Acquire knowledge, by training and/or experience, in the medical and behavioral treatment of children in families affected by substance abuse.
2. Continually monitor the child/adolescent's health needs.
3. Be knowledgeable about the proper use of consultations.
4. Throughout the course of health care treatment, continually monitor and treat, or refer for care, any psychiatric or behavioral disturbances.
5. Be available to the child or adolescent and the family, as needed, for ongoing care and support.

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Other Technical Assistance Publications (TAPs) include:

TAP 1 *Approaches in the Treatment of Adolescents with Emotional and Substance Abuse Problems* **PHD580**
TAP 2 *Medicaid Financing for Mental Health and Substance Abuse Services for Children and Adolescents* **PHD581**
TAP 3 *Need, Demand, and Problem Assessment for Substance Abuse Services* **PHD582**
TAP 4 *Coordination of Alcohol, Drug Abuse, and Mental Health Services* **PHD583**
TAP 5 *Self-Run, Self-Supported Houses for More Effective Recovery from Alcohol and Drug Addiction* **PHD584**
TAP 6 *Empowering Families, Helping Adolescents: Family-Centered Treatment of Adolescents with Alcohol, Drug Abuse, and Mental Health Problems* **BKD81**
TAP 7 *Treatment of Opiate Addiction With Methadone: A Counselor Manual* **BKD 151**
TAP 8 *Relapse Prevention and the Substance-Abusing Criminal Offender* **BKD121**
TAP 9 *Funding Resource Guide for Substance Abuse Programs* **BKD152**
TAP 10 *Rural Issues in Alcohol and Other Drug Abuse Treatment* **PHD662**
TAP 11 *Treatment for Alcohol and Other Drug Abuse: Opportunities for Coordination* **PHD663**
TAP 12 *Approval and Monitoring of Narcotic Treatment Programs: A Guide on the Roles of Federal and State Agencies* **PHD666**
TAP 13 *Confidentiality of Patient Records for Alcohol and Other Drug Treatment* **BKD156**
TAP 14 *Siting Drug and Alcohol Treatment Programs: Legal Challenges to the NIMBY Syndrome* **BKD175**
TAP 15 *Forecasting the Cost of Chemical Dependency Treatment Under Managed Care: The Washington State Study* **BKD176**
TAP 16 *Purchasing Managed Care Services for Alcohol and Other Drug Abuse Treatment: Essential Elements and Policy Issues* **BKD167**
TAP 17 *Treating Alcohol and Other Drug Abusers in Rural and Frontier Areas* **BKD174**
TAP 18 *Checklist for Monitoring Alcohol and Other Drug Confidentiality Compliance* **PHD722**
TAP 19 *Counselor's Manual for Relapse Prevention With Chemically Dependent Criminal Offenders* **PHD723**
TAP 20 *Bringing Excellence to Substance Abuse Services in Rural and Frontier America* **BKD220**
TAP 21 *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* **BKD246**
TAP 22 *Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers* **BKD252**
TAP 23 *Substance Abuse Treatment for Woman Offenders: Guide to Promising Practices* **BKD310**
TAP 24 *Welfare Reform and Substance Abuse Treatment Confidentialy: General Guidance for Reconciling Need to Know and Privacy* **BKD336**
TAP 25 *The Impact of Substance Abuse Treatment on Employment Outcomes Among AFDC Clients in Washington State* **BKD367**
TAP 26 *Identifying Substance Abuse Among TANF-Eligible Families* **BKD410**
TAP 27 *Navigating the Pathways: Lessons and Promising Practices in Linking Alcohol and Drug Services with Child Welfare* **BKD436**

Other TAPs may be ordered by contacting the National Clearinghouse for Alcohol and Drug Information (NCADI), (800) 729-6686 or (301) 468-2600, TDD (for hearing impaired), (800) 487-4889.

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